

Michigan Journal of Race and Law

Volume 4

1999

The Charleston Policy: Substance or Abuse?

Kimani Paul-Emile

Brennan Center for Justice, New York University School of Law

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Recommended Citation

Kimani Paul-Emile, *The Charleston Policy: Substance or Abuse?*, 4 MICH. J. RACE & L. 325 (1999).

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THE CHARLESTON POLICY: SUBSTANCE OR ABUSE?

Kimani Paul-Emile*

In 1989, the Medical University of South Carolina (MUSC) adopted a policy that, according to subjective criteria, singled out for drug testing, certain women who sought prenatal care and childbirth services would be tested for prohibited substances. Women who tested positive were arrested, incarcerated and prosecuted for crimes ranging from misdemeanor substance possession to felony substance distribution to a minor. In this Article, the Author argues that by intentionally targeting indigent Black women for prosecution, the MUSC Policy continued the United States legacy of their systematic oppression and resulted in the criminalizing of Black Motherhood.

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* Staff attorney, Poverty Program at the Brennan Center for Justice at the New York University School of Law. B.A. 1993, Brown University; J.D. 1996, Georgetown University Law Center. I owe thanks to many people who reviewed and offered invaluable insights on various incarnations of this article. They include: Eleanor Brown, Laura Davis, Jennifer Gonnerman, Gillian Metzger, Gail Yamauchi, and Dr. Barbara Paul-Emile. I would also like to thank Priscilla Smith for graciously providing me the opportunity to write the amicus brief upon which this article is based.

INTRODUCTION

Reinforcing centuries of race, class and gender biases, in 1989 the Medical University of South Carolina¹ ("MUSC") instituted the Interagency Policy of Management of Substance Abuse During Pregnancy ("Policy"). Created as part of a collaboration between the City of Charleston, South Carolina ("Charleston"), the Charleston Police Department ("CPD"), Ninth Judicial Circuit Solicitor's Office ("Solicitor's Office") and MUSC, the Policy sanctioned the Solicitor's Office to criminally prosecute substance-dependent pregnant women under the state's child endangerment laws. The Policy established a protocol which required: (i) testing, without consent, women who sought obstetrical care; (ii) disclosing the results of these tests to third persons; (iii) arresting women who tested positive; and (iv) criminally prosecuting them.

Purportedly established "to ensure appropriate management of patients abusing illegal drugs during pregnancy,"² the Policy punished, instead of treated, women who became pregnant while substance addicted and who chose to carry their pregnancies to term. While the Policy implementers maintained that their actions were intended only to help endangered children and deter pregnant women from self-destructive behavior, virtually every woman arrested pursuant to the Policy was Black.

Under the new Policy, Black women were arrested in vastly disproportionate numbers relative to their approximately thirty-three percent of the general Charleston area population.³ During the first eight months of the Policy, all of the women reported by MUSC to the Solicitor's Office and subsequently arrested and incarcerated by the CPD were Black.⁴ In fact, during the entire period that the Policy was enforced, all but one of the women reported to the CPD and arrested were Black, and the one White woman reported was distinguished in medical charts as having a "Negro boyfriend."⁵

Equally troubling is the fact that these women were arrested and prosecuted only for their addiction to cocaine. This was notwithstanding the fact that substance addiction is a disease and thus

1. MUSC is a state-administered hospital located in Charleston, South Carolina that receives both state and federal funding.

2. Medical University of South Carolina, Policy M-7, *Management of Drug Abuse During Pregnancy*, in MUSC MEDICAL CENTER POLICY MANUAL (1989) [hereinafter *Management of Drug Abuse During Pregnancy*].

3. See Brief of Appellants at 25, *Ferguson v. City of Charleston* (4th Cir. Apr. 7, 1998) (No. 97-2512).

4. See *id.* at 23.

5. See Joint Appendix at 1366-69, *Ferguson v. City of Charleston* (4th Cir. Apr. 7, 1998) (No. 97-2512) [hereinafter JA], noted in Brief of Appellants, *supra* note 3, at 23.

not subject to criminal penalties. Moreover, the Policy targeted cocaine-dependent women despite medical evidence showing that cocaine does not cause irreversible harm to a fetus. The Policy's underlying assumption that cocaine is singularly and irreversibly harmful to a fetus, though widely believed, is actually unsupported by medical science. Given the consensus of the medical community on the issue of drug dependency during pregnancy, MUCS's institution of the Policy was not accidental—nor was its particular impact upon indigent Black women.

Women who tested positive for cocaine during prenatal visits or hospitalizations prior to delivery were ostensibly entitled to an opportunity to receive treatment before they were arrested. However, the implementers of the Policy were well aware that the Charleston area lacked drug treatment facilities equipped to provide the services necessary to meet the needs of low-income pregnant women and new mothers.⁶ Indeed, there were no substance abuse treatment programs that provided any kind of child care, which created a tremendous barrier to treatment for many pregnant women.⁷ Thus, the Policy frightened pregnant women away from necessary medical attention. This was so despite the fact that the most effective way of ensuring and protecting maternal and fetal health is to provide substance abuse treatment and proper prenatal care.⁸

6. Until 1992, there was not one drug treatment program in all of South Carolina designed to meet the specific needs of pregnant and parenting substance-addicted women and their children. See SOUTH CAROLINA COMMISSION ON ALCOHOL AND DRUG ABUSE, ANNUAL REPORT 1991-1992 66 (1992) (announcing the April 1992 opening of South Carolina's first residential treatment program for women). In addition, MUSC's own treatment center did not accept pregnant women. See CENTER FOR REPRODUCTIVE LAW & POLICY, REPRODUCTIVE FREEDOM IN FOCUS, PUNISHING WOMEN FOR THEIR BEHAVIOR DURING PREGNANCY: AN APPROACH THAT UNDERMINES WOMEN'S HEALTH AND CHILDREN'S INTERESTS 4 (1996) [hereinafter PUNISHING WOMEN FOR THEIR BEHAVIOR DURING PREGNANCY].

7. According to Louise Haynes, the Director of the Office of Women's Services for the South Carolina Commission on Alcohol and Drug Abuse from 1988 to 1992 (a state agency designed to develop substance abuse treatment programs for women), in the fall of 1989 there were no substance abuse treatment facilities in the Charleston area that provided any kind of child care. See JA, *supra* note 5, at 903, noted in Brief of Appellants, *supra* note 3, at 21. This created a significant barrier to women with children seeking treatment. See Brief of Appellants, *supra* note 3, at 21.

8. See Helene M. Cole, *Legal Interventions During Pregnancy*, 264 JAMA 2663, 2668-69 (1990).

[I]t is often too late to ensure a healthy pregnancy once it has begun. . . . The birth of a healthy baby, then, depends in part on the woman's general health and well-being before conception as well as on the amount and quality of prenatal care. Health care before pregnancy can ameliorate disease, improve risk status, and help prepare the woman for childbearing.

Women who tested positive at the time of delivery were denied treatment as an alternative to arrest and incarceration and were summarily arrested.⁹ All told, the CPD arrested thirty women,¹⁰ many of whom were still recovering from delivery. One woman was handcuffed to her bed throughout delivery. Others, weak and in pain, still bleeding heavily from childbirth, vomiting, and dressed only in hospital gowns, were shackled and taken to holding cells, where they were made to wait for hours.¹¹ Some women were even handcuffed to chains that went around their stomachs.¹² One woman was allowed only a blanket to cover her hospital gown as she was wheeled half-naked out of the hospital to a waiting police car.¹³

Many of those arrested were not given the opportunity to contact family members to arrange for the care of their young children. Some women were jailed during their pregnancies, taken to the hospital for delivery, and then returned to jail in shackles and chains.¹⁴ In one instance, on October 7, 1989, a woman checked into MUSC eight months pregnant and experiencing premature labor. After her condition stabilized three days later, a nurse told the woman that she was being released to go home. However, soon thereafter, policemen arrested her in her hospital room. She was handcuffed, shackled, and taken out of the hospital in a wheelchair. Though she was informed that her arrest was for distribution of cocaine to a minor, she was not told that the minor in question was her fetus. Her bail was set at \$80,000. She spent five hours in a holding cell, then three weeks in a sick bay at the jail. She was transported back and forth from the jail to MUSC for treatment for premature labor, all the while handcuffed and shackled to the hospital bed.¹⁵

Another woman targeted under the Policy gave birth on October 13, 1989. Despite the fact that she was bleeding so profusely that she needed four sanitary napkins to absorb the blood and had passed a small clot the night before, she was arrested the next morning while in the recovery room and charged with child neglect. The woman was transported to the police station handcuffed, wearing only a hospital gown open at the back. Because she was still

9. See JA, *supra* note 5, at 182, 1417; Brief of Appellants, *supra* note 3, at 20.

10. Brief of Appellants, *supra* note 3, at 23 ("Of the 30 women who were reported to the police and arrested throughout the entire Policy, 29 were African American and the one White woman had a 'Negro boyfriend,' as was noted by Nurse Shirley Brown in the woman's medical records.").

11. See Brief of Appellants, *supra* note 3, at 17-20.

12. See JA, *supra* note 5, at 181, *noted in* Brief of Appellants, *supra* note 3, at 18.

13. See Brief of Appellants, *supra* note 3, at 18-20.

14. See *id.*

15. See *id.*

bleeding and experiencing severe pain, she had to be assisted into both the police car and the station. Once at the station, she was kept in a holding cell for four to five hours and later brought to a larger facility. She was handcuffed and shackled at all times, still dressed in the revealing hospital gown which, by this time, was soaked in blood. She was never offered any help with her continued bleeding.¹⁶

The Policy was in place from 1989 through 1994, even though it: (i) disproportionately impacted women of color; (ii) placed an unconstitutional burden on women's right to reproductive freedom; (iii) unlawfully criminalized the health status of pregnant, substance-dependent women; (iv) undermined, rather than improved, maternal and fetal health; (v) did not reduce cocaine use, improve pregnancy outcomes, or increase the number of women successfully completing drug treatment; and (vi) contravened the consensus of medical, public health and children's rights organizations across the country that such policies are inimical to maternal and fetal health and welfare.

On September 1, 1994, MUSC discontinued the Policy after the Civil Rights Division of the Department of Health and Human Services threatened to cancel federal funding. Less than three weeks later, the Federal Office of Protection from Research Risks, following a separate investigation, placed MUSC on probation for its involvement in the Policy, which it found to constitute unethical human experimentation.¹⁷ These federal investigations were prompted by a multimillion dollar civil rights lawsuit filed in 1993 against the City of Charleston, South Carolina, by women who sought obstetrics care from MUSC but instead were arrested pursuant to the Policy.¹⁸

While the federal enforcement actions against MUSC focused on the hospital's violations of the law and medical ethical standards, they did not address the degree to which the Policy was rooted in a desire to penalize Black women for their decision to carry their pregnancies to term while substance-addicted. This article seeks to demonstrate that the Policy punished Black women for their health status and their decision to continue wanted pregnancies, and

16. See *id.* at 19.

17. See Philip H. Jos et al., *The Charleston Policy on Cocaine Use During Pregnancy: A Cautionary Tale*, 23 J.L. MED. & MED. ETHICS 120, 120 (1995) (noting that because the MUSC ignored requisite procedures, the renewal of its Multiple Project Assurance was deferred for at least one year and that MUSC was required to take corrective action) (citing letter to MUSC officials dated Sept. 30, 1994 from the Compliance Oversight Branch, Division of Human Subjects Protection, Office of Protection from Research Risks).

18. *Ferguson et al. v. City of Charleston et al.*, No. 2-93-2624-2 (D.S.C. filed Oct. 5, 1993) (challenge brought pursuant to 42 U.S.C. § 1983 alleging that the Policy violated plaintiffs' constitutional and federal statutory rights and constituted an abuse of process under South Carolina common law).

concomitantly deterred women from seeking necessary prenatal care and assistance from health and social service professionals. MUSC's Policy not only had a decided bias against Black and indigent women,¹⁹ but was the product of a society that has chosen to make race and gender the centerpieces of its social policy for hundreds of years. To examine these prosecutions in an ahistorical context would mask the underlying racism, misogyny and discrimination inherent in the Policy. Tactics such as those employed by MUSC have historically been used to subordinate women of color by controlling and restricting their reproductive autonomy.

In this article, I will attempt to lift the veil of apparent coincidence and reveal that racism and gender bias were intrinsic to, if not the driving force behind, the implementation of the Policy. Part I will outline the development and implementation of the Policy, while Part II will examine the Policy within an historical context, thereby exposing the full meaning, significance and implications of incarcerating pregnant, substance-dependent Black women. Under this framework, Part III will examine each aspect of the Policy in order to demonstrate the ways in which the Policy not only detrimentally impacted, but specifically singled out Black women for discriminatory treatment.

Finally, Part IV will explore the implications of targeting primarily Black women for prosecution and expose the ways in which the Policy impacted the material condition of Black mothers and the health and welfare of their children. This Part will also make clear the gross injustice inherent in using the criminal justice system, instead of the health care system, to address a public health issue. In addition, Part IV will argue that the Policy dangerously allowed the interests of the fetus to subsume those of the mother. In so doing, the Policy unconstitutionally burdened the women's fundamental rights to liberty, privacy and reproductive freedom by punishing them for their decision to carry their pregnancies to term.

In sum, by addressing these aspects of a larger social problem that primarily implicate Black women, and by choosing the criminal justice system as the remedial mechanism, the implementers of the Policy created an unconstitutional and extremely ill-advised program.

19. See Blank, *supra* note 8, at 90; see also Jos et al., *supra* note 17, at 124; Dorothy E. Roberts, *Punishing Drug Addicts Who Have Babies: Women of Color, Equality, and the Right of Privacy*, 104 HARV. L. REV. 1419, 1432-36 (1991) (arguing that prosecution of drug-addicted mothers today is a violation of equal protection); Ira J. Chasnoff, et al., *The Prevalence of Illicit Drug or Alcohol Use During Pregnancy and Discrepancies in Mandatory Reporting in Pinellas County, Florida*, 322 NEW ENG. J. MED. 1202, 1202 (1990) (finding that despite similar numbers of positive results in first prenatal visits for Black and White women, Black women were significantly more likely to be reported).

The Policy not only targeted Black women in the scope of its applications and effects, but specifically singled them out for punitive treatment. In this way, the creators and implementers of the Policy criminalized Black motherhood.

I. DEVELOPMENT AND IMPLEMENTATION OF THE POLICY

In the late summer of 1989, Shirley Brown ("the Nurse"), a case manager in the Obstetrics Department at MUSC, became concerned about what she described as an "epidemic among pregnant Black women of cocaine abuse or addiction."²⁰ Her interest stemmed from a radio report covering the arrest of a pregnant, drug dependent woman under South Carolina's child abuse statute in another part of the state.²¹ On the same day she heard the report, the Nurse approached MUSC's general counsel, who then wrote a letter about this occurrence to then South Carolina Solicitor Charles Condon.²² Soon thereafter, MUSC's general counsel formed an ad hoc task force consisting of representatives from MUSC, the Solicitor's Office and the CPD.²³ The task force convened its first meeting on September 18, 1989.²⁴

At the meeting, Condon notified the task force that he interpreted the term "child" in the state's child neglect statute²⁵ and the

20. See JA, *supra* note 5, at 1396, noted in Brief of Appellants, *supra* note 3, at 4.

21. In relevant part, South Carolina's statute dealing with unlawful conduct towards children provides:

(A) It is unlawful for a person who has charge or custody of a child, who is the parent or guardian of a child, or who is responsible for the care and support of a child to:

- (1) place the child at unreasonable risk of harm affecting the child's life, physical or mental health, or safety;
- (2) do or cause to be done unlawfully or maliciously any bodily harm to the child so that the life or health of the child is endangered or likely to be endangered; or
- (3) willfully abandon the child.

(B) A person who violates subsection (A) is guilty of a felony and for each offense, upon conviction, must be fined in the discretion of the court or imprisoned not more than ten years, or both.

S.C. CODE ANN. § 20-7-50 (West Supp. 1998).

22. See Brief of Appellants, *supra* note 3, at 4.

23. See *id.* The task force was comprised of: (i) MUSC representatives—e.g., the Nurse, Drs. Roger Newman and Edgar Horger III, the current and former Directors of MUSC's Maternal, Fetal Medicine Division, respectively, and General Counsel Joe Good; (ii) representatives from the Solicitor's Office, including Solicitor Charles Condon; and (iii) CPD representatives, including Police Chief Reuben Greenberg. See *id.* at 4-5.

24. See *id.* at 5.

25. See S.C. CODE ANN. § 20-7-50 (West Supp. 1998).

word "person" under the state statute criminalizing the "distribution [of controlled substances] to minors under eighteen" to include viable fetuses.²⁶ His strikingly broad interpretation of those terms provided the basis for extending the statutes to cover maternal use of substances during pregnancy that could potentially harm a fetus. At that time, no South Carolina court had ever read the statutes to cover viable fetuses,²⁷ and the South Carolina Legislature had repeatedly considered and rejected attempts to expand the reach of the state's child endangerment laws to include fetuses and pregnant women's drug use.²⁸ Yet, according to Condon's interpretation, maternal use of harmful substances had to be reported pursuant to state statute. This was so notwithstanding the fact that proof of harm to the child was not required.

The task force members decided to test a targeted group of pregnant patients at MUSC for drugs and to report positive test results for cocaine directly to the participating law enforcement agencies—the CPD and the Solicitor's Office. Pursuant to this program, which would later become the Policy, the obstetric service of MUSC adopted a protocol for treating pregnant women who sought health care at the hospital.²⁹ This protocol did not apply to MUSC's private obstetrical patients.

In accordance with the protocol, women who wished to receive obstetric care from MUSC were required to sign a consent to medical

26. S.C. CODE ANN. § 44-53-440 (West Supp. 1998) provides that:

Any person eighteen years of age or over who . . . distribut[es] a controlled substance [including] crack cocaine to a person under eighteen years of age is guilty of a felony and, upon conviction, must be imprisoned for not more than twenty years or fined not more than thirty thousand dollars, or both, and the sentence may not be suspended and probation may not be granted.

27. Although Condon's interpretation was later adopted by the South Carolina Supreme Court in *Whitner v. South Carolina*, 492 S.E.2d 777 (S.C. 1997), it has been rejected by every other court in the nation to consider it. See e.g., *Wisconsin ex rel. Angela M.W. v. Kruzicki*, 561 N.W.2d 729, 731 (Wis. 1997) (rejecting forced commitment of a pregnant women into drug treatment in order to protect the fetus); *State v. Ashley*, 701 So.2d 338, 342 n.13 (Fla. 1997) (stating that expectant mother may not be criminally charged with the death of her child resulting from self-inflicted injuries during the third trimester of pregnancy).

28. See Arlene Levinson, *Cocaine Mom's Case Spotlights Fetus Rights*, POST & COURIER (Charleston, S.C.), March 15, 1998 at 7B. (Condon stated, "[i]n our state, the rights of the fetus don't come from the mother, they come from God."); S.1495 (1989–1990), reintroduced as S.75 (1990–1991) (to, *inter alia*, require drug testing of newborns).

29. See Edgar O. Horger, III et al., *Cocaine in Pregnancy: Confronting the Problem*, 86 J. S.C. MED. ASS'N. 527, 528–29 (1990).

treatment form which included consent for a urine screen.³⁰ Drug screens were performed only on patients who exhibited certain indicators of drug use, including: no prenatal care; late prenatal care after 24 weeks of gestation; incomplete prenatal care; abruptio placentae; intrauterine fetal death; preterm labor; intrauterine growth retardation; previously known drug or alcohol abuse; and unexplained congenital abnormalities.³¹ The Policy defined illegal drugs as "heroin, crack/cocaine, amphetamines, and any other drug illegally ingested by the patient that medical authorities deemed a threat to the life and safety of the unborn child."³² Urine samples obtained from the targeted patients then entered a legal chain of custody.³³

If a patient's drug screen indicated drug use, she was to be shown a film on the dangers of cocaine use during pregnancy³⁴ and provided a statement to sign indicating that she understood the potential harm and consequences of continued drug use. At that time, an appointment with the substance abuse clinic, and follow-up appointments with the obstetrics clinic, were to be made for the patient. In addition, according to the protocol, those patients who screened positive for drug use were to be given a written statement from the Solicitor indicating that they had been offered an opportunity for rehabilitation, and that they would be arrested if they failed to get substance abuse treatment and prenatal care.³⁵

CPD operational guidelines mandated the drafting of criminal reports and the issuance of arrest warrants for those patients who tested positive for drugs and who failed to attend a scheduled appointment for substance abuse treatment or prenatal care.³⁶ Patients who tested positive for the substances outlined in the Policy a second time were to be taken into immediate custody upon release from the hospital, even if the CPD was unable to obtain an arrest warrant. Similarly, any patient who delivered an infant who tested positive for the substances delineated in the Policy was to be arrested immediately upon medical release, and her newborn removed and placed in protective custody by the Department of Social Services. The patient was to be charged with possession of an illegal substance if the gestation was twenty-seven weeks or less,

30. See STATE COUNCIL ON MATERNAL, INFANT AND CHILD HEALTH, OFFICE OF THE GOVERNOR, 3 1991 SOUTH CAROLINA STUDY OF DRUG USE AMONG WOMEN GIVING BIRTH: LEGAL ISSUES 25-26 (1992) [hereinafter MICH REPORT VOL. III].

31. See JA, *supra* note 5, at 1415; Brief of Appellants, *supra* note 3, at 7.

32. *Management of Drug Abuse During Pregnancy*, *supra* note 2, at 9.

33. See Jos et al., *supra* note 17, at 121.

34. See *id.*

35. See *id.*

36. See *id.*

and possession and distribution of an illegal substance to a person under eighteen if gestation was twenty-eight weeks or more.³⁷ If the patient or her child tested positive for drugs during delivery, she was to be charged with unlawful neglect of a child.³⁸

Implemented on October 1, 1989 and formally adopted eleven days later as the "Policy,"³⁹ these arrangements resulted in arrests pursuant to the Policy even before the first memorandum regarding the adoption of the Policy had been distributed to MUSC personnel, and over a month before the MUSC Executive Committee's approval of the Policy on November 27, 1989.⁴⁰

II. THE POLICY EMBODIES THE LONG-STANDING SOCIAL TREND OF CRIMINALIZING BLACK MOTHERHOOD

In order to clarify the meaning and implications of targeting these Black women for prosecution, this case must be placed in an historical context. Over the last two centuries, tactics and policies such as the one employed by MUSC have been used to subordinate women of color by controlling and restricting their reproductive autonomy. From the horrors of the Middle Passage and slavery through the state sponsored abuses of Jim Crow to modern day racism and sexism, Black women have had an experience distinct from that of their Black brethren and White women.⁴¹ Black women have

37. See S.C. CODE ANN. § 44-53-370(c)(1) (West Supp. 1998) (defining the first offense of possession of cocaine as a misdemeanor carrying a maximum two year sentence); S.C. CODE ANN. § 44-53-370 and § 44-53-440 (West Supp. 1998) (stating that distribution of crack cocaine to a person under age eighteen carries a maximum sentence of twenty years).

38. See S.C. CODE ANN. § 20-7-50 (West Supp. 1998) (describing unlawful conduct towards a child as a felony carrying a maximum sentence of ten years).

39. See Brief of Appellants, *supra* note 3, at 6.

40. See *id.*

41. The first Black women to come to the United States arrived in Jamestown, Virginia, on a seized Spanish cargo ship and were offered, in exchange for food, to Dutch sailors. See LERONE BENNETT JR., BEFORE THE MAYFLOWER 29-30 (Penguin Books 5th ed. 1985) (1962); see also A. LEON HIGGINBOTHAM, JR., IN THE MATTER OF COLOR 20-22 (1978) (discussing the status of the first twenty Blacks to arrive in Jamestown in 1619). In 1705, the Virginia General Assembly announced that "[a]ll Negro, mulatto and Indian slaves shall be held, taken and adjudged to be real estate, in the same category as livestock and household furniture, wagons, and goods." KATHY RUSSELL ET AL., THE COLOR COMPLEX 11 (1992).

En route to the colonies, slave women were tortured in ways that Black men were not.

The placing of African men in chains was to prevent possible uprisings. As white slavers feared resistance and retaliation at the hands of African men, they placed as much distance between themselves and black male slaves as was possible on board. It was only in relation-

inherited a unique legacy of physical, sexual and psychological brutalization.⁴² Because this experience has been systematically ignored and marginalized, the privileged body politic, through legislative and judicial action, has constructed an image of "Black motherhood" that denies the realities of history.⁴³

Both an economic and political system, American slavery was an institution under which Whites, through the threat or use of force, bled as much labor as possible from Blacks and people of

ship to the black female slave that the white slaver could exercise freely absolute power, for he could brutalize and exploit her without fear of harmful retaliation. Black female slaves moving freely about the deck were a ready target for any white male who might choose to physically abuse and torment them. Initially every slave on board the ship was branded with a hot iron. A cat-o'-nine-tails was used by the slavers to lash those Africans that cried out in pain or resisted the torture. Women were lashed severely for crying. They were stripped of their clothing and beaten on all parts of their body. . . . After the branding, all slaves were stripped of any clothing. The nakedness of the African female served as a constant reminder of her sexual vulnerability. Rape was a common method of torture slavers used to subdue recalcitrant black women. The threat of rape or other physical brutalization inspired terror in the psyches of displaced African females. Robert Shufeldt, an observer of the slave trade, documented the prevalence of rape on slave ships. He asserts, "In those days many a negress was landed upon our shored [sic] already impregnated by someone of the demonic crew that brought her over."

BELL HOOKS, *AIN'T I A WOMAN* 17-18 (1981). See generally GERDA LERNER, *BLACK WOMEN IN WHITE AMERICA* (1972) (discussing how Black women have been denied their own history, and providing an interpretation of their history so that they may have an autonomous definition).

42. As Lerner has described:

The sexual exploitation of black women by white men was so widespread as to be general. Some black women made the best of an inescapable necessity; others tried to strike an advantageous bargain. Many were assaulted not by their masters but by overseers, neighboring youth or the master's sons. The point here is that such exploitation was always possible and could in no way be fought or avoided—it was yet another way in which the total helplessness of the slave against arbitrary authority was institutionalized.

LERNER, *supra* note 41, at 46; see also JACQUELINE JONES, *LABOR OF LOVE, LABOR OF SORROW* 19 (1985) ("Indeed, in the severity of punishment meted out to slaves, little distinction was made between the sexes. Black women attained parity with black men in terms of their productive abilities in the cotton fields; as a result they often received a proportionate share of the whippings. In response to an interviewer's inquiry, a former Virginia slave declared, 'Beat women! Why sure he [master] beat women. Beat women jes lak men. Beat women naked an' wash 'em down in brine.'").

43. See *infra* pp. 14-24.

mixed race.⁴⁴ By law, both male and female slaves were denied all basic rights, including property ownership, literacy and the ability to maintain the integrity of their families. However, although slave women were expected to toil in fields alongside male slaves, they were also forced to engage in domestic work for their captors, tend to their masters' children, and then find time to care for and nurture their own families.⁴⁵

Slave women were not only denied basic freedoms, but lacked protection from social, economic and sexual abuses. According to one historian of the slave trade:

Christopher Nichols, an escaped slave living in Canada, remembered how his master laid a woman on a bench, threw her clothes over her head, and whipped her. Another refugee remembered that when his mother was whipped, she was stripped completely naked: "Dey

44. See JONES, *supra* note 42, at 13 (discussing Black women in slavery); see also LERNER, *supra* note 41, at 5 (discussing the plantation slave system).

45. As Jones has stated:

The definition of slave women's work is problematical. If work is any activity that leads either directly or indirectly to the production of marketable goods, then slave women did nothing but work. Even their efforts to care for themselves and their families helped to maintain the owner's work force and to enhance its overall productivity. Tasks performed within the family context—childcare, cooking, and washing clothes, for example—were distinct from labor carried out under the lash in the field or under the mistress's watchful eye in the Big House.

JONES, *supra* note 42, at 14.

During the 1850's, at least 90% of slave women over the age of sixteen worked more than 261 days per year, eleven to thirteen hours per day. See *id.* at 18. In a 1937 interview, a Kentucky ex-slave described her experiences under slavery:

"The things that my sister May and I suffered were so terrible. . . . It is best not to have such things in our memory. . . . Work, work, work," she said it had consumed all her days (from dawn until mid-right) and all her years (she was only eight when she began minding her master's children and helping the older women with their spinning). "I been so exhausted working, I was like an inchworm crawling along a roof. I worked till I thought another lick would kill me." On Sundays, "the only time they [the slaves] had to themselves," she recalled, women washed clothes and some of the men tended their small tobacco patches. As a child she loved to play in the haystack, but that was possible only on "Sunday evenings, after work."

Id. at 13.

Another former slave explained that as a girl, no matter how cold the temperature, she was forced to plow with a mule: "'Sometimes me hands get so cold I jes' cry.'" *Id.* at 18.

didn't care nothing 'bout it. Let everybody look on at it." Similarly, Henry Bibb reported a whipping where a woman's "naked quivering flesh" was "tied up and exposed to the public gaze of all."

Without doubt, some whippings of female slaves were sexually suggestive. The man who whipped Henry Bibb's wife was often heard by Bibb to exclaim that "he had rather paddle a female than eat when he was hungry." The whipping of a thirteen-year-old Georgia slave girl also had sexual overtones. The girl was put on all fours "sometimes her head down and sometimes her head up" and beaten until froth ran from her mouth. Solomon Northup's master was not above whipping his slave Patsey in such a manner, either. According to Northup, Master Epps was a man possessed with "brute passion." Nothing satisfied him more than having a few drinks and whipping Patsey.⁴⁶

Black women were severely abused under the institution of slavery, almost beyond definition, in that they were sexually and physically assaulted by both Black and White men,⁴⁷ and were victimized with equal cruelty by White women. Often angered by their husbands' illicit sexual relationships with their essentially powerless female slaves, White women frequently vented their rage not at their husbands but at their perceived rivals.⁴⁸ Indeed, slave women who gave birth to light-skinned children often felt the wrath of irate wives who, suspecting that their husbands had fathered the children, frequently sold the children off.⁴⁹

Moreover, White women were known to dole out whippings and punishment as viciously and cruelly as their male counterparts. While White women in the antebellum South were also ultimately victimized by the institution of slavery since White men used the subjugation of women and people of color to maintain their patriarchal dominance, this powerlessness often manifested itself as rage against slave women. Indeed, it is well documented that "some of the most sadistic behavior inflicted on female house servants was at

46. DEBORAH GRAY WHITE, *AR'N'T I A WOMAN?* 33 (1985).

47. *See id.* at 152-53.

48. Lerner notes that "Black women frequently fought tenaciously though unsuccessfully against the degrading and hated illicit relationships with their masters. In such cases, they suffered cruel punishment until they succumbed. Frequently this drew upon them the hatred and enmity of their mistresses." LERNER, *supra* note 41, at 46.

49. *See WHITE, supra* note 46, at 41.

the hands of White wives in retaliation for their husbands' affairs."⁵⁰
According to one account:

[A] white mistress returned home unexpectedly from an outing, opened the doors of her dressing room, and discovered her husband raping a thirteen year old slave girl. She responded by beating the girl and locking her in a smokehouse. The girl was whipped daily for several weeks. When older slaves pleaded on the child's behalf and dared to suggest that the white master was to blame, the mistress simply replied, "She'll know better in the future. After I've done with her, she'll never do the likes again through ignorance."⁵¹

A. The Iconography of Black Female Sexuality

The American system of slavery fostered the separation of the categories of race and gender which led to the sexualization of race and the creation of the stereotypes surrounding Black female sexuality and motherhood. As a result of this dichotomy, the experience of antebellum Black women was different from that of any other group in this country.⁵² Slave women were subjected to a double oppression that neither White women nor Black men endured.⁵³

Under slavery, Black women had little, if any, protection from the assaults that they were forced to sustain at the hands of their captors as Southern laws did not even consider the rape of a Black

50. RUSSELL, *supra* note 41, at 21.

51. HOOKS, *supra* note 41, at 36–37 (citing STANLEY FELDSTEIN, *ONCE A SLAVE* 132 (1971)).

52. See *id.* at 28 ("The impossible task confronts the black woman. If she is rescued from the myth of the negro, the myth of the woman traps her. If she escapes the myth of the woman, the myth of the negro still ensnares her. Since the myth of the woman and the myth of the negro are so similar, to extract her from one gives the appearance of freeing her from both.").

53. As Lerner has described:

In general, the lot of black women under slavery was in every respect more arduous, difficult and restricted than that of the men. Their work and duties were the same as that of the men, while childbearing and rearing fell upon them as as [sic] an added burden. Punishment was meted out to them regardless of motherhood, pregnancy or physical infirmity. Their affection for their children was used as a deliberate means of tying them to their masters, for children could always be held as hostage in case of the mother's attempted escape. The chances of escape for female slaves were fewer than those for males. Additionally, the sexual exploitation and abuse of black Women by White men was a routine practice.

LERNER, *supra* note 41, at 15.

woman a crime.⁵⁴ In fact, from emancipation through more than two-thirds of this century, not one Southern White man was convicted of raping or attempting to rape a Black woman.⁵⁵ The crime, however, was so pervasive that according to the National Commission on the Causes and Prevention of Violence, the low number of reported incidents of such rapes by 1969 indicated not that the crime was a rare occurrence, but rather that "white males have long had nearly institutional access to Negro women with relatively little fear of being reported."⁵⁶

It was not until 1860 that the Mississippi state legislature enacted legislation criminalizing the rape of a Black woman.⁵⁷ The crime was made punishable by death or whipping. The law applied solely to Black men and covered only the rape or attempted rape of Black females under the age of twelve.⁵⁸ Because the law could only be enforced against a Black male perpetrator and the victim had to be a child, the statute effectively codified the vulnerability of Black women to rape.

Countless slave women were violated and ravaged by a country that denied them basic freedoms, including the right to their own bodies. Slave women were not recognized as human beings, much less women, and were therefore denied access to the conventional standards of female treatment. The White male power structure enforced the Victorian code of modesty on White women, and the sensibilities of the pre-revolutionary South dictated that the prototypical woman be "the ideal wife and mother; as good as possible,

54. During the 1859 trial of a slave sentenced to death in the rape of a ten-year-old female slave, the judge held that "the original indictment could not be sustained under common law or under the statutes of Mississippi because 'it charges no offence known to either system. . . . There is no act which embraces either the attempted or actual commission of a rape by a slave on a female slave.'" Similarly, in another case, a Tennessee judge remanded a slave to jail for attempting to rape a White woman, stating that "what gave 'the offense its enormity' was the fact that [the victim] was white." Such an act committed on a *black woman*, would not," he noted, "be punished with death." WHITE, *supra* note 46, at 152 (emphasis in original). See generally *George (a slave) v. State*, 37 Miss. 316, 320 (1859) (holding that no legal remedy is available for the rape of a female slave child because "masters and slaves cannot be governed by the same common system of laws: so different are their positions, rights, and duties."); EUGENE GENOVESE, *ROLL, JORDAN, ROLL* 33 (1976) ("Rape meant, by definition, rape of white women, for no such crime as rape of a black woman existed at law. Even when a black man sexually attacked a black woman he could only be punished by his master; no way existed to bring him to trial or convict him is so brought.").

55. See WHITE, *supra* note 46, at 164-65.

56. *Id.* at 164 (citing DONALD J. MULVIHILL, *CRIMES OF VIOLENCE, A STAFF REPORT TO THE NATIONAL COMMISSION ON THE CAUSES AND PREVENTION OF VIOLENCE* (1969)); see also *id.* at 149-62.

57. See WHITE, *supra* note 46, at 152-53.

58. See *id.*

delicate, pure, submissive, calm, frail, small and dependent."⁵⁹ The slave woman, on the other hand, was restricted to the circumscribed role of worker, breeder and temptress. While women in the antebellum South were expected to conform to the mores of the time, which demanded that their bodies be fully concealed from view, slave women were forced to exist in various states of undress.⁶⁰

This situation facilitated the creation of the archetypal "Jezebel" image. The Jezebel figure worked to enforce the stereotype of the slave woman as a deviant, libidinal being.⁶¹ According to the dictates of this image, the slave woman actively sought sexual advances from White men. Any resistance on her part was regarded as only for show and therefore not to be heeded. The supposed unlimited sexual appetite of enslaved Black women was used by their captors to rationalize rape and other brutal treatment.⁶² Thus the Jezebel image was manipulated to justify not only the miscegenation, cruel-

59. Leith Mullings, *Images, Ideology, and Women of Color*, in *WOMEN OF COLOR IN U.S. SOCIETY* 267 (Maxine Baca Zinn and Bonnie Thornton Dill eds., 1994).

60. See WHITE, *supra* note 46, at 31-34.

61. As Lerner discussed:

By assuming a different level of sexuality for all blacks than that of whites and mythifying their greater sexual potency, the black woman could be made to personify sexual freedom and abandon. A myth was created that all black women were eager for sexual exploits, voluntarily 'loose' in their morals and therefore deserved none of the consideration and respect granted white women. Every black woman was, by definition, a slut according to this racist mythology; therefore, to assault her and exploit her sexually was not reprehensible and carried with it none of the normal communal sanctions against such behavior. A wide range of practices reinforced this myth: the laws against intermarriage; the denial of the title 'Miss' or 'Mrs.' to any black woman; the taboos against respectable social mixing of the races; the refusal to let black women customers try on clothing in stores before making a purchase; the assigning of single toilet facilities to both sexes of blacks; the different legal sanction against rape, abuse of minors and other sex crimes when committed against white or black women.

LERNER, *supra* note 41, at 163-64; see also K. SUE JEWELL, FROM MAMMY TO MISS AMERICA AND BEYOND: CULTURAL IMAGES AND THE SHAPING OF U.S. SOCIAL POLICY 36 & 46 (1993) (discussing the Jezebel stereotype and its application to black slave women); WHITE, *supra* note 46, at 27-61. See generally Joan R. Tarpley, *Blackwomen, Sexual Myth, and Jurisprudence*, 69 TEMP. L. REV. 1343 (1996) (discussing the history of the Jezebel myth and its continuing relation to American jurisprudence).

62. Jewell, *supra* note 61, at 211 ("[S]lave owners . . . attributed these liaisons to the hypersexuality of the female slave who was purported to be the aggressor or seducer."); see also White, *supra* note 46, at 38 ("It was black women who, many claimed, tempted men of the superior caste. White men, it was argued, never had to use authority or violence to obtain compliance from bonded women because the latter's morals were so relaxed.").

ties and sexual abuse endured by slave women, but also to explain the abundance of children of mixed racial heritage.

B. *Reproductive Prisoners: "Breeder" Women*

The Black woman in slavery was chattel. She existed as the property of another human being, who was at liberty to do with her as he/she wished.⁶³ This was particularly true for child-bearing slave women who were subject to a separate and distinct form of terror. On the auction block, Black women's naked bodies were handled by prospective buyers so that they might discern the woman's reproductive capabilities.⁶⁴ Buyers at slave auctions often "kneaded women's stomachs in an attempt to determine how many children a woman could have."⁶⁵ At one documented slave auction, the auctioneer exclaimed to a slave woman waiting to be sold, "[s]how your neck, Betsey. There's a breast for you; good for a round dozen before she's done child-bearing."⁶⁶ When there was doubt about a woman's reproductive ability, she could be taken by her prospective pur-

63. As Lerner explained:

The plantation slave system formed a separate and distinct culture which bound both master and slave in a complex and interdependent relationship. Although the race prejudice of whites, which antedated the institutionalization of slavery, shaped the system's form and character, its object was not genocide. American slavery was above all a labor system, designed to extract the maximum amount of profit from unwilling and dependent subjects. In practice, the production process and the objects of the system set some limits to its arbitrariness and cruelty. Self-interest of the master in the preservation of his property generally dictated the maintenance of minimum standards designed for survival of the slave, but it was the barest survival under the harshest conditions. On the other hand, the deeply ingrained racism of American culture, which designated Blacks not only as enslaved people but as inherently inferior because of their race, tended to worsen the conditions of American slaves as the system advanced in time. The mutually reinforcing interplay of racism and economic motivation made the slave system increasingly oppressive.

LERNER, *supra* note 41, at 5.

Major periodicals carried articles detailing optimal conditions under which bonded women were known to reproduce, and the merits of a particular 'breeder' were often the topic of parlor or dinner table conversations. The fact that something so personal and private became a matter of public discussion prompted one ex-slave to declare that 'women wasn't nothing but cattle.'

WHITE, *supra* note 46, at 31.

64. See White, *supra* note 46, at 32.

65. *Id.*

66. *Id.*

chaser and a physician to a private room where she would be inspected more thoroughly.⁶⁷

Pregnant slaves and slave mothers were not immune from the daily abuses that the rest of their kin fell prey to. Pregnant and nursing slave women could be whipped “so that blood and milk flew mingled from their breasts.”⁶⁸ More often, however, pregnant slaves were “made to lie face down in a specially dug depression in the ground” prior to being whipped so as to protect the fetus, little more than a commodity or the master’s potential asset.⁶⁹ “Breeder” women, as they were called, were often kept pregnant, bearing children as frequently as every twelve months.⁷⁰ Some women were given inducements by slave owners to produce children. One plantation manual instructed that “women with six children alive at any one time are allowed all Saturday to themselves.”⁷¹ Women were seldom allowed to choose their mates, and, if not impregnated by their captors, were often compelled to couple with other slaves.⁷²

Those slave women incapable of having children were frequently separated from their husbands and sold.⁷³ Because a Black woman’s relative value was in her ability to reproduce, infertile women were worth less than those who could propagate.⁷⁴ In fact, so many slave owners attempted to sell off infertile slaves through deceit and misrepresentation that Southern judges and juries became accustomed to dealing with such cases. Indeed, if a slave woman, certified by the seller as being able to bear children, was sold, and it

67. *See id.*

68. JONES, *supra* note 42, at 20.

69. *See id.*

70. *See* LERNER, *supra* note 41, at 47–48 (an 87 year old former slave woman explained the lot of the “breeder slave”: “Wunner dese here womans was my Antie en she say dat she skacely call to min’ he e’r whoppin’ her, ‘case she was er breeder woman en’brought in chillun ev’y twelve mont’s jes lak a cow bringin’ in a calf. . . . He orders she can’t be put to no strain ‘casen uv dat.”).

71. WHITE, *supra* note 46, at 100.

72. *See id.* at 102 (telling the story of a young woman who objected to reproducing with a male slave. The master asserted that he paid “big money,” explaining, “I wants you to raise me childrens.”).

73. According to a former slave, “[I]f a woman was a good breeder, ‘they was proud of her;’ if not, they got rid of her.” *Id.*

74. For example:

In 1852 an Alabama master bought three women only to find out that one of them had syphilis, another had gonorrhea, and the third suffered from the effects of an umbilical hernia, all of which rendered them, in the opinion of the buyer, “scarcely valuable as breeders.”

Id. at 101.

could be proven that the seller knew she was infertile, the sale would be voided and the proceeds refunded.⁷⁵

The Black woman as slave in the colonial South was exploited for her reproductive abilities as well as her physical labor.⁷⁶ After Congress outlawed the slave trade in 1801, slave women's reproductive capabilities became of paramount importance to the slaveholding states. Consequently, the lot of Black women did not improve until well into the twentieth century. Many Black women were limited to the same role they served during slavery, when they were systematically denied the rights to education, to vote, and to maintain the integrity of their own bodies.⁷⁷ In many respects, the role of modern Black women can be said to have been defined by the slavery experience since they continue to be bound by the inseparable combination of oppressions based on gender, race and economic status.⁷⁸

75. See *id.*

76. See Nell I. Painter, *Thinking About the Languages of Money and Race: A Response to Michael O'Malley, "Specie and Species,"* 99 AM. HIST. REV. 396, 398 (1994) ("Enslaved black people were not simply likened to money, they were a kind of money."). With regard to the value of a slave woman of childbearing age, Painter discusses "the literal value of sex in slavery, of women as sexual property, reproduction that has cash value, and the enhancement of that value when the act that engenders it joins men who were white with women who were black—sex that was bound to be coerced." *Id.*; see also JONES, *supra* note 42, at 14:

One North Carolina slave woman, the mother of fifteen children, used to carry her youngest with her to the field each day, and "When it get hungry she just slip it around in front and feed it and go right on picking or hoeing. . ." symbolizing in one deft motion the equal significance of her productive and reproductive function to her owner.

77. With *Brown v. Board of Education*, 347 U.S. 483, 495 (1954), 58 years of contrary precedent set by *Plessy v. Ferguson*, 163 U.S. 537, 548 (1896), were struck down, including laws enforcing racial segregation in four states, including South Carolina, as violating the Fourteenth Amendment's Equal Protection Clause. See *Harris v. McRae*, 448 U.S. 297, 316–17 (1980) (states participating in the Medicaid program are not obligated to fund medically necessary abortions); *South Carolina v. Katzenbach*, 383 U.S. 301, 334 (1966) (upholding the Voting Rights Act of 1965's ban on literacy tests, and recounting how southern states enacted measures specifically designed to prevent Blacks from voting and structured safeguards so Whites, even if illiterate, could vote).

78. See Angela P. Harris, *Race and Essentialism in Feminist Legal Theory*, 42 STAN. L. REV. 581, 585 (1990) (arguing that gender essentialism silences the experiences of Black women); Roberts, *supra* note 19, at 1424 (noting that the prosecution of drug-addicted Black mothers can be seen as punishment for an inseparable combination of gender, race, and economic status); Judy Scales-Trent, *Black Women and the Constitution: Finding Our Place, Asserting Our Rights*, 24 HARV. C.R.-C.L. L. REV. 9, 10–11 (1989) (discussing the legal system's difficulties in categorizing "black women" when trying to protect the rights of "blacks" and "women").

C. Contemporary Images: The Unfit Mother

The principal tenets of American slavery created some of the most lasting negative cultural images and representations of Black women. Archetypes such as the licentious Jezebel figure and the passive Breeder Woman continue to shape the way we conceive of Black maternity well into modern times. The influence of these iconographic figures is particularly evident in the context of Black women's reproductive autonomy.

With the abolition of slavery the ability of Black women to bear children was no longer deemed a financial asset but a liability—a drain upon the economy. Black motherhood became suspect. Throughout this century, family planning initiatives aimed at Black women were often little more than attempts to limit Black women's reproductive capabilities.⁷⁹ In fact, during the 1930's the federal government subsidized the first birth control clinics in order to lower the Black birth rate and thereby control the Black population.⁸⁰ Even the nascent birth control movement, led by Margaret Sanger, openly supported and promoted the use of birth control as a means of limiting the reproductive freedoms of Black women.⁸¹

In 1939, Sanger and her associates at the Birth Control Federation of America initiated the "Negro Project," established to regulate the reproductive abilities of Black women thought to "still breed carelessly and disastrously, with the result that the increase among Negroes, even more than among whites, is from that portion of the population least intelligent and fit, and least able to rear children properly."⁸² Advocating abortion, contraception and eugenics or compulsory sterilization for Black women, these birth control pioneers saw reproductive technology as a viable means of containing the proliferation of "human weeds."⁸³

79. See Robert G. Weisbord, *GENOCIDE? BIRTH CONTROL AND THE BLACK AMERICAN* (1975) (discussing the notion held by many Black people that family planning programs could be used to commit race genocide); see also William A. Darity, *Family Planning, Race Consciousness and the Fear of Race Genocide*, 62 AM. J. PUB. HEALTH 1454, 1454–56 (1972) (same).

80. See Dorothy E. Roberts, *Crime, Race, and Reproduction*, 67 TUL. L. REV. 1945, 1970–71 (1993).

81. See Linda Gordon, *WOMAN'S BODY, WOMAN'S RIGHT: A SOCIAL HISTORY OF BIRTH CONTROL IN AMERICA* 281–83, 332–33 (1976). In the *American Birth Control League's Journal*, Sanger wrote, "More children from the fit, less from the unfit—that is the chief issue of birth control." *Id.* at 281.

82. *Id.* at 332.

83. See Charlotte Rutherford, *Reproductive Freedoms and African American Women*, 4 YALE J.L. & FEMINISM 255, 273 (1992); see also GEORGE GRANT, *GRAND ILLUSIONS: THE ILLUSIONS OF PLANNED PARENTHOOD* 63, 65 (2d ed. 1992) (account of Margaret Sanger's life).

In 1965, Daniel P. Moynihan, currently U.S. Senator from New York, "legitimized" the widely accepted depiction of the Black family as dysfunctional, and the Black mother as pathological due to her alleged inability to adhere to White middle-class social norms.⁸⁴ This image of the Black mother was used to justify programs and policies aimed at restricting Black maternity. For example, during the 1960's, in an attempt to discourage childbearing and reduce the number of individuals on welfare, the federal government dramatically increased funding for family planning clinics, placing a disproportionate number in Black and Latino communities.⁸⁵

Throughout the 1970's, Black women were threatened with the withdrawal of welfare benefits if they refused to agree to sterilization.⁸⁶ During this period, twenty-five percent of indigent White women were sterilized compared to thirty-four percent of indigent Black women.⁸⁷ In a suit brought by indigent teenage Black women, a federal district court found that an estimated 100,000 to 150,000 poor women were sterilized each year under federally funded programs.⁸⁸ Many physicians refused to deliver babies or perform abortions on pregnant Black women unless they consented to sterilization.⁸⁹ In addition, during the 1970's and 1980's Public Assistance

84. See OFFICE OF POLICY PLANNING AND RESEARCH, U.S. DEP'T OF LABOR, *THE NEGRO FAMILY: THE CASE FOR NATIONAL ACTION* 29-34 (1965).

85. See Annette Dula, *African American Suspicion of the Healthcare System is Justified: What Do We Do About It?*, 3 CAMBRIDGE Q. HEALTHCARE ETHICS 347, 349-50 (1994) (showing that the clinics were placed with the intent to reduce minority births).

86. See Roberts, *supra* note 80, at 1971.

87. See Laurie Nsiah-Jefferson, *Reproductive Laws, Women of Color, and Low-Income Women*, 11 WOMEN'S RTS. L. REP. 15, 31 (1989). In addition, a 1982 study found that not only were Black women of all marital statuses more likely than White women to use sterilization as a contraception method, but Black women in the South had the highest rates of hysterectomy and tubal ligation in the United States. See *id.* Thus, in response to the abuses of the 1970's, the Department of Health and Human Services adopted regulations aimed at ensuring that informed consent be obtained from all women who receive federally funded sterilizations. See 442 C.F.R. §§ 441.250-.259 (1991) (sterilizations); 42 C.F.R. § 441.257 (1991) (informed consent); 42 C.F.R. § 441.258 (1991) (consent form requirements). However, the impact of those regulations remains to be seen due to poor consent monitoring procedures and the lack of publicly available data on the efficacy of the regulations. See Nsiah-Jefferson, *supra*, at 30.

88. See *Relf v. Weinberger*, 372 F. Supp. 1196, 1199 (D.D.C. 1974); see also *Cox v. Stanton*, 529 F.2d 47 (4th Cir. 1975) (reversing dismissal of a claim brought by a Black woman who was permanently sterilized after she agreed to temporary sterilization when threatened with termination of welfare benefits); Darci Elaine Burrell, *The Norplant Solution: Norplant and the Control of African American Motherhood*, 5 UCLA WOMEN'S L.J. 401, 423 (1995) (discussing *Relf v. Weinberger*).

89. See Roberts, *supra* note 80, at 1971.

officials duped Black welfare claimants into having their teenage daughters sterilized.⁹⁰

Modern reproductive technology continues to be used to foil Black women's reproduction. Almost immediately after its December 10, 1990 approval by the United States Food and Drug Administration, proposals for the use of the contraceptive Norplant⁹¹ were aimed at controlling Black women's fertility.⁹² It was not long before all fifty states had incorporated Norplant into their welfare systems, providing either reimbursement for the cost of Norplant to women receiving Aid to Families with Dependent Children or a cash bonus for those women who agreed to be implanted with the device.⁹³ High schools considered offering Norplant to teenage girls,⁹⁴ and courts and legislatures debated conditioning probation on the acceptance of Norplant.⁹⁵ Thus Norplant, like the proposals of the eugenicists at the turn of the century and the coerced sterilization of poor Black women during the 1970s and 1980s, was seen as a solution to the "problem" of Black women having babies.

Today, a disproportionately high percentage of Black women live below the poverty line.⁹⁶ Black women are also five times more

90. See Dula, *supra* note 85, at 350.

91. See Burrell, *supra* note 88, at 402 ("Norplant consists of six, match-sized, silicon tubes which release a steady stream of the synthetic hormone levonorgestrel into the bloodstream to prevent pregnancy. The tubes are surgically inserted under the skin of a woman's arm and prevent conception for up to five years.") (citations omitted).

92. See generally Burrell, *supra* note 88 (arguing that Norplant proposals aimed at poor Black women were based on the notion that Black women are deviant and thus less deserving of motherhood than White women).

93. See David S. Coale, Note, *Norplant Bonuses and the Unconstitutional Conditions Doctrine*, 71 TEX. L. REV. 189, 189-90 (1992) (discussing state funded programs that provide incentives for the use of Norplant); Dorothy E. Roberts, *Norplant's Threat to Civil Liberties and Racial Justice*, N.J. L.J., July 26, 1993, at 20.

94. See, e.g., Tim Larimer, *High School Offers Birth Control Implant, Blacks Disagree on Merits of Program*, DALLAS MORNING NEWS, Mar. 17, 1993, at A37.

95. See Janet F. Ginzberg, Note, *Compulsory Contraception as a Condition of Probation: The Use and Abuse of Norplant*, 58 BROOK. L. REV. 979, 979-80 (1992) (on January 2, 1991, a California judge ordered Darlene Johnson, a Black woman convicted of child abuse, to receive Norplant as a condition of her probation). The Ohio legislature introduced a bill intended to expand the definition of child neglect to cover the use of controlled substances during pregnancy and which would require women twice convicted of this new crime to use Norplant. See Deborah Ann Bailey, Comment, *Maternal Substance Abuse: Does Ohio Have An Answer?*, 17 U. DAYTON L. REV. 1019, 1032-33 (1992) (discussing OHIO REV. CODE ANN. § 2151.03(A) (Page 1998); § 2919.221(B) (2) (Page 1996)).

96. In 1991, 9.8% of White men and 12.7% of White women lived in poverty, while 26.2% of Hispanic men, 28.5% of Black men, 31.2% of Hispanic women, and 36.5% of Black women lived in poverty. See CHERYL RUSSELL & MARGARET AMBRY, *THE OFFICIAL GUIDE TO AMERICAN INCOMES* 283 (1993); see also U.S. BUREAU OF THE CENSUS, U.S. DEP'T OF COMMERCE, *CURRENT POPULATION REPORTS*, SERIES P60-185,

likely to be poor and on welfare, and are three times more likely to be unemployed than White women.⁹⁷ In addition, Black women are paid less than White women and Black and White men.⁹⁸ Poor Black women often enjoy few options with regard to their medical care, including choice of physicians and the hospitals they can attend. This lack of viable choices has a direct impact on the health of Black women and their children.⁹⁹

Black women are 3.8 times more likely to die from pregnancy-related causes than White women.¹⁰⁰ Almost one out of ten Black infants is born to a mother who received late or no prenatal care,¹⁰¹ and among Black teenage mothers under the age of fifteen, that figure increases to two in ten.¹⁰² Moreover, Black women receive prenatal care later in their pregnancies than White women, if they

POVERTY IN THE UNITED STATES: 1992, at 1 tbl. 1 (Number, Poverty Rate, and Standard Errors of Persons, Families, and Unrelated Individuals Below the Poverty Level: 1992 and 1991), 147 tbl. 23 (Poverty Threshold, By Size of Family and Number of Related Children, 1992) (1993). Although two-thirds of poor Americans are White, the poverty rate for Blacks is 33.3%, the highest in the nation, compared to the national poverty rate of 14.5%. In 1992, close to 40 million people were living under the official federal poverty level, which was \$9137 for a family of two, \$11,186 for a family of three and \$14,335 for a family of four. *See id.*

97. *See Roberts, supra* note 19, at 1432 n.60 (citing NADJA ZALOKAR, U.S. COMM'N ON CIVIL RIGHTS, *THE ECONOMIC STATUS OF BLACK WOMEN* 1 (1990)).

98. In 1991 the median earnings of White men working full-time, year-round was \$30,266, while the median earnings of Black men, White women, and Black women were \$22,075, \$20,794 and \$18,720, respectively. *See Russell & Ambry, supra* note 96, at 51-52; *see also* Scales-Trent, *supra* note 79, at 9 n.2 & 10 n.1 (noting that the racial gap in unemployment rates plus the gender gap is not as great as the racial-gender gap, suggesting that race and gender interact to magnify the effects of each independently).

99. White Americans, on average, have a life expectancy that is 6.5 years longer than that of Black Americans. *See* 6 U.S. DEP'T OF HEALTH AND HUMAN SERVS., *REPORT OF THE SECRETARY'S TASK FORCE ON BLACK AND MINORITY HEALTH* 1 (1986) [hereinafter *SECRETARY'S TASK FORCE*]. Although, proportionately, more White women suffer from breast cancer, Black women are twice as likely to die from the disease. *See* ANGELA Y. DAVIS, *WOMEN, CULTURE, & POLITICS* 57 (1989). Likewise, Black women are also significantly more likely to die from diabetes, hypertension, or cardiovascular disease, and three times more likely to suffer from high blood pressure or lupus than similarly situated White women. *See id.* at 58.

100. A recent state-by-state study of maternal mortality revealed "huge disparities between black and white women" and found that the best rates for Black women remained "higher or in about the same range as the worst rates for white women." Sheryl Gay Stolberg, *Racial Divide Found in Maternal Mortality*, N.Y. TIMES, June 18, 1999, at A24 (internal quotations omitted); *see also* DANA HUGHES, ET AL., CHILDREN'S DEFENSE FUND, *THE HEALTH OF AMERICA'S CHILDREN: MATERNAL AND CHILD HEALTH DATA BOOK* 10 (1989) (revealing data that Black women are far more likely to die of pregnancy-related causes than White women).

101. *See* CHILDREN'S DEFENSE FUND, *BLACK AND WHITE CHILDREN IN AMERICA: KEY FACTS* 76 (1985).

102. *See id.*

receive it at all.¹⁰³ As a result, the children of Black women are twice as likely to die during infancy.¹⁰⁴ Indeed, in 1992 the Black infant mortality rate was 16.8 per thousand births compared to 6.9 for Whites.¹⁰⁵ In Washington, D.C., the mortality rate among Black infants is triple that for the entire country.¹⁰⁶ In addition, grossly disproportionate to their 15% representation in the general population, Black children comprise 39.0% to 42.4% of the children in the foster care system.¹⁰⁷

Yet the root causes of these seemingly intractable social ills are difficult to remedy because, while there is a legal framework in which to investigate issues relating to Blacks and a separate framework for issues relating to women, we lack a legal paradigm to analyze issues that concern Black women. Black women experience a double oppression due to their status as “Black” and as “women;” the two are not separable components of their identity.¹⁰⁸ The creation of this destructive dichotomy is a direct byproduct of this country’s legacy of slavery.

The enduring image of the “deviant” Black mother remains with us today: the current political and social climate relies upon racist stereotypes and images to create a class of mothers regarded as not only deserving of their difficult social and economic situation, but also unfit to raise their own children.¹⁰⁹ The Policy embodies a vivid manifestation of these negative historical representations of Black maternity.

103. See *id.* at 75; see also Stolberg, *supra* note 100 (reporting that Black women are less likely to have adequate prenatal care than White women).

104. See DAVIS, *supra* note 99, at 58.

105. See DOROTHY E. ROBERTS, *KILLING THE BLACK BODY* 183 (1997).

106. See *id.* at 184.

107. See Annie Woodley Brown & Barbara Bailey-Etta, *An Out-of-Home Care System in Crisis: Implications for African American Children in the Child Welfare System*, 76 *CHILD WELFARE* 65, 74–75 (1997). According to Dorothy Roberts, “Black mothers’ bonds with their children have been marked by brutal disruption, beginning with the slave auction where family members were sold to different masters and continuing in the disproportionate state removal of Black children to foster care.” Dorothy E. Roberts, *The Unrealized Power of Mother*, 5 *COLUM. J. GENDER & LAW* 141, 146 (1995).

108. See Kimberle Crenshaw, *Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory and Antiracist Politics*, 1989 *U. CHI. LEGAL F.* 139, 140 (arguing that “Black women are sometimes excluded from feminist theory and antiracist policy discourse because both are predicated on a discrete set of experiences that often does not accurately reflect the intersection of race and gender.”).

109. See Note, *Dethroning the Welfare Queen: The Rhetoric of Reform*, 107 *HARV. L. REV.* 2013, 2018–25 (1994) (examining the recipients of Aid to Families with Dependent Children and welfare programs).

III. SINGLING OUT POOR BLACK WOMEN FOR PROSECUTION

Virtually every aspect of the Policy demonstrates that it operated solely to punish Black women for their substance addiction during pregnancy, rather than to address the health problems attendant to such circumstances. The decisions of the Policy creators to (i) implement the Policy at the one hospital in the state that serves a disproportionately high Black population, (ii) utilize subjective identifying criteria, and (iii) target cocaine to the exclusion of all substances that could affect maternal and fetal health all contributed to inevitably skew the Policy to disproportionately impact Black women. Moreover, the fact that the Policy violated MUSC's own standards on informed consent and patient confidentiality (recognized with regard to all other patients) belies any explanation for the Policy's singular effects on Black women other than the Policy framers' specific intent to target indigent Black women for punitive treatment.

A. The Policy Discriminated In the Scope of its Application and Effects

1. Only Patients at MUSC Were Targeted

MUSC was the only hospital with which the CPD maintained a formal policy of arresting pregnant and postpartum women who tested positive for cocaine, and the only hospital at which such arrests were made.¹¹⁰ Notwithstanding that the jurisdiction of the Solicitor's Office includes two counties¹¹¹ and that the CPD's jurisdiction spanned the entire Charleston area,¹¹² the Policy was developed for and implemented only at MUSC. MUSC is a public hospital that provides most of the publicly-funded care for the Charleston area, serving a predominantly Black and economically disadvantaged population.

The Policy did not apply to nearby private hospitals,¹¹³ nor did any other public hospital employ such a

110. See JA, *supra* note 5, at 1327, *noted in* Brief of Appellants, *supra* note 3, at 7-8 (noting that arrests were not made at the private hospitals in the area nor at any other public health clinic in the tri-county region).

111. See JA, *supra* note 5, at 1323, *noted in* Brief of Appellants, *supra* note 3, at 7 (noting that the Solicitor's office had jurisdiction throughout Berkeley and Charleston counties).

112. See Brief of Appellants, *supra* note 3, at 7

113. Indeed, MUSC's general counsel stated that the Policy implementors were given "probably more latitude" to test the new program at MUSC, a publicly funded hospital, than they would have had at a private hospital. JA, *supra* note 5, at 867-68, *noted in* Brief of Appellants, *supra* note 3, at 8. One MUSC physician candidly ac-

program.¹¹⁴ In fact, MUSC was the only hospital within at least a 50 mile radius which provided obstetric care for indigent and Medicaid sponsored patients.¹¹⁵ The population served by MUSC was disproportionately Black (70%) compared to Charleston's population (30% Black).¹¹⁶ The patient population at other area hospitals was only approximately one-third Black.¹¹⁷ Thus the Policy expressly exonerated wealthier patients and "whiter" populations.

Despite the fact that there is no significant difference across race and class lines in rates of controlled substance use,¹¹⁸ all but one of the women prosecuted under the Policy, from 1989 until 1994, were low-income Black women who sought prenatal or other health care

knowledgeed that implementing the policy at a private hospital "would cause too much trouble, too much of a problem." JA, *supra* note 5, at 1216-17, *noted in* Brief of Appellants, *supra* note 3, at 8 n.7.

114. CPD Chief Greenberg admitted that MUSC was the only hospital with which CPD had a formal policy to arrest pregnant women who tested positive for cocaine, and was also the only hospital at which such arrests were made. See JA, *supra* note 5, at 889-890, *noted in* Brief of Appellants, *supra* note 3, at 8. The difference between the racial composition of the MUSC patients and the racial makeup of patients at other Charleston area hospitals under the jurisdiction of the CPD and Solicitor's Office is statistically significant. See *Hunter v. Underwood*, 471 U.S. 222, 227 (1985) (holding that a disparity of 1.7 times the norm demonstrates disparate impact).

115. See Horgner, *supra* note 29, at 530.

116. See JA, *supra* note 5, at 1184-85, *noted in* Brief of Appellants, *supra* note 3, at 4.

117. See Brief of Appellants, *supra* note 3, at 25. ("While the MUSC's patient population was approximately two-thirds African American, the patient population at other area hospitals was only approximately one-third African American, a difference of approximately 18 standard deviations.").

118. See Chasnoff, *supra* note 19, at 1204 (detailing the results of a study testing drug use among pregnant women showing that neither socioeconomic grouping nor a subject's race or ethnicity predicted a positive drug test); see also Daniel R. Neuspiel, *Racism and Perinatal Addiction*, ETHNICITY & DISEASE, Winter/Spring 1996, at 47-48 (looking at rates of drug use among different ethnic groups). According to a survey conducted by the Southern Regional Project on Infant Mortality:

Newspaper reports in the 1980s sensationalized the use of crack cocaine and created a new picture of the typical female addict: young, poor, black, urban, on welfare, the mother of many children, and addicted to crack. In interviewing nearly 200 women for this study, a very different picture of the typical chemically dependent woman emerges. She is most likely white, divorced or never married, age 31, a high school graduate, on public assistance, the mother of two or three children, and addicted to alcohol and one other drug. It is clear from the women we interviewed that substance abuse among women is not a problem confined to those who are poor, black or urban, but crosses racial, class, economic and geographic boundaries.

SHELLY GEHSAN, SOUTHERN REGIONAL PROJECT ON INFANT MORTALITY, A STEP TOWARD RECOVERY: IMPROVING ACCESS TO SUBSTANCE ABUSE TREATMENT FOR PREGNANT AND PARENTING WOMEN 21 (1993) [hereinafter SRPIM REPORT].

from MUSC.¹¹⁹ According to one MUSC physician, the Policy was only applied to infants born in her unit, not to babies born at private hospitals and subsequently transferred to her unit, nor was there a policy to test such infants.¹²⁰ Additionally, a counselor from the Charleston County Substance Abuse Commission explained that under the Policy only patients from MUSC's high-risk ob/gyn department were referred to her office for drug treatment.¹²¹ Instead of being offered treatment for their substance dependency, these women were arrested when hospital personnel reported their status to the CPD.¹²²

When the Policy was implemented, the racial composition of women who tested positive for both legal and illegal drugs mirrored the makeup of the maternity ward population at MUSC: 68% Black and 32% White.¹²³ Thus, from October 1, 1988 until September 30, 1989, the percentage of Black versus White maternity patients who tested positive for drugs mirrored the percentage of Black and White patients within the entire maternity population,¹²⁴ confirming the assumption that both Black and White maternity patients at MUSC would use potentially harmful substances at approximately the same rate.¹²⁵ However, the racial composition of MUSC maternity patients who tested positive for cocaine was markedly different. Ninety percent (120 out of 133) of the total number of women who tested positive for cocaine were Black, while only 10% (13 of 133 women) were White.¹²⁶

119. See Brief of Appellants, *supra* note 3, at 23–25. The chance of arresting 30 Black women consecutively is 1 in 165,103, corresponding to approximately five standard deviations from the expected level, and the probability of this occurring accidentally or by chance is 0.000006. See *id.* at 24.

120. See JA, *supra* note 5, at 126, noted in Brief of Appellants, *supra* note 3, at 8.

121. See Brief of Appellants, *supra* note 3, at 9.

122. The only White woman prosecuted under the Policy was the mother of a child fathered by a Black man. One of the Policy implementers, in fact, specifically noted on the woman's medical records that she had a "Negro boyfriend." See Brief of Appellants, *supra* note 3, at 23.

123. See Brief of Appellants, *supra* note 3, at 25.

124. See *id.* at 27. After implementation of the Policy and the new subjective criteria for testing, the proportion rose considerably, by an amount equal to approximately 10.5 standard deviations. See JA, *supra* note 5, at 1344–46, noted in Brief of Appellants, *supra* note 3, at 27.

125. In Pinellas County, Florida, despite the fact that drug use is equally prevalent in both Black and White women, Black women were 9.58 times more likely to be reported for substance abuse than White women. See Chasnoff, *Discrepancies in Mandatory Reporting*, *supra* note 19, at 1205.

126. See JA, *supra* note 5, at 1338–39, noted in Brief of Appellants, *supra* note 3, at 25. These percentages were calculated using the binomial distribution method. According to this system, the difference is 5.44 standard deviations from the norm and is thus statistically significant. See Brief of Appellants, *supra* note 3, at 25–26. The possibility of such a stark differential occurring accidentally is between 1 in 100,000

Despite the demographic breakdown of clinic patients at MUSC, nearly all those reported pursuant to the policy and arrested were Black.¹²⁷ The striking disparity between Black women and White women arrested and prosecuted under the policy suggests that the Black women singled out under the Policy were denied equal protection under the law.¹²⁸

2. The Policy Lacked a Scientific Basis

The clearly foreseeable disparate impact of MUSC's policy was compounded by the fact that it rested on an unstable basis. According to the protocol, urine drug screens were performed on patients who met certain criteria, including, *inter alia*: no prenatal care, late prenatal care, incomplete prenatal care, intrauterine fetal death, preterm labor, intrauterine growth retardation, and previous drug use.¹²⁹ This was the first step towards arrest under the Policy, notwithstanding the fact that these criteria did not indicate the use of cocaine or any other controlled substance.¹³⁰

Before long, the Policy required neonatologists to test the infants of mothers who met the criteria. Despite the Policy implementers' assertions to the contrary, the Medical Director of the Neonatal Intensive Care Unit explained that they did not test the infants for medical reasons, as had previously been the case.¹³¹ After the adoption of the Policy, MUSC personnel were required to maintain a formal "chain of custody" for the urine specimens collected pursuant to the Policy, although this was not done with urine samples taken for purely medical reasons.¹³² Prior to October 1989,

and 1 in 1,000,000. See JA, *supra* note 5, at 1341-42, noted in Brief of Appellants, *supra* note 3, at 26.

127. See Richard Green Jr., *MUSC Won't Report Cocaine Use*, POST & COURIER (Charleston, S.C.), Sept. 7, 1994, at 1 (reporting that most women arrested pursuant to the policy were Black); Gina Kolata, *Racial Bias Seen Against Pregnant Addicts*, N.Y. TIMES, July 20, 1990, at A13 (reporting that of the estimated sixty known prosecutions for prenatal drug exposure nationwide, 80% were brought against non-White women).

128. See *Wayte v. United States*, 470 U.S. 598, 607-09 (1985) (selective enforcement of criminal statutes violates equal protection); see also Dorothy Roberts, *supra* note 19, at 1425 (arguing that the prosecution of substance-addicted Black women who decide to carry their pregnancies to term is unconstitutional).

129. See JA, *supra* note 5, at 1415; Brief of Appellants, *supra* note 3, at 7.

130. See JA, *supra* note 5, at 731-33 (according to Dr. Ira Chasnoff, it would be "medically senseless" to consider MUSC's criteria indicative of cocaine use).

131. See JA, *supra* note 5, at 1225, noted in Brief of Appellants, *supra* note 3, at 7 (noting that prior to the Policy, infants were tested for medical reasons, but after the Policy was adopted, infants were selected for testing based solely on the Policy criteria).

132. See JA, *supra* note 5, at 1416, noted in Brief of Appellants, *supra* note 3, at 7.

MUSC personnel reported the use of various different drugs, including alcohol, to the Department of Social Services ("DSS").¹³³

3. The Policy Only Applied to Cocaine Use

A study of South Carolina women who had just given birth revealed that 5% of the womens' urine tested positive for either alcohol, cocaine, marijuana or other illicit drugs; 2.5% tested positive for marijuana; 1.9% tested positive for alcohol; and a mere 0.79% tested positive for cocaine.¹³⁴ Thus for every 100,000 births in South Carolina in 1990, approximately 2974 infants were exposed to barbiturates, 1000 infants were exposed to marijuana, opiates and alcohol, yet only 422 infants were exposed to cocaine.¹³⁵ However, pursuant to the Policy, only the prenatal ingestion of cocaine would lead to arrest and incarceration.¹³⁶

MUSC and the solicitors purportedly chose to criminalize only prenatal cocaine-dependency in order to prevent fetal harm from exposure to this drug. This was so despite the fact that many other legal and illegal substances ingested by a pregnant woman could harm a fetus as much as cocaine, if not more so.¹³⁷ Moreover, because the cheapest and most accessible form of cocaine, commonly referred to as crack, tends to be concentrated in urban and Black communities, the decision to test only cocaine-addicted patients was, in reality, a thinly veiled attempt to target Black women.¹³⁸

133. See Brief of Appellants, *supra* note 3, at 9.

134. See STATE COUNCIL ON MATERNAL, INFANT AND CHILD HEALTH, OFFICE OF THE GOVERNOR, 1991 SOUTH CAROLINA PREVALENCE STUDY OF DRUG USE AMONG WOMEN GIVING BIRTH 19 (1991) [hereinafter MICH PREVALENCE STUDY].

135. See *id.* at 31.

136. See JA, *supra* note 5, at 768, 1263-64; Brief of Appellants, *supra* note 3, at 10.

137. Studies have indicated that prenatal cocaine exposure can contribute to low birthweight and prematurity, conditions that under the Policy lead to drug screens. See SRPIM REPORT, *supra* note 118, at 5. However, many physiological, environmental, and behavioral factors can also lead to these conditions including: pre-eclampsia, diabetes, hypertension, lead exposure, cigarette smoking, poor nutrition, alcohol consumption, and lack of prenatal care. See COMMITTEE TO STUDY THE PREVENTION OF LOW BIRTHWEIGHT, INSTITUTE OF MEDICINE, PREVENTING LOW BIRTHWEIGHT 1-7 (1985) [hereinafter COMMITTEE ON LOW BIRTHWEIGHT].

138. According to Professor Dorothy Roberts:

Although different forms of substance abuse prevail among pregnant women of various socioeconomic level and racial and ethnic backgrounds, inner-city Black communities have the highest concentrations of crack addicts. Therefore, selecting crack abuse as the primary fetal harm to be punished has a discriminatory impact that cannot be medically justified.

The few early studies that triggered public alarm over the effects of cocaine use during pregnancy were seriously flawed and have since been contradicted and discredited.¹³⁹ Recent medical and scientific studies have revealed significant methodological errors in these previous reports, including the lack of control groups, the failure to follow the subsequent health of newborns, the failure to isolate the effects of cocaine use from those associated with the use of other drugs, and the exclusive reliance on case reports.¹⁴⁰ In fact, contrary to the few misleading early reports, broad-based studies have found no detectable increase in the rate or severity of birth defects associated with *in utero* cocaine exposure.¹⁴¹

Roberts, *supra* note 19, at 1435. Moreover, while White women are more than twice as likely to use marijuana than Black women, Black women are nearly six times as likely to use crack cocaine. See MICH PREVALENCE STUDY, *supra* note 134, at 7. See generally Dwight L. Greene, *Abusive Prosecutors: Gender, Race & Class Discretion and the Prosecution of Drug-Addicted Mothers*, 39 BUFF. L. REV. 737 (1991) (discussing the broad prosecutorial discretion, under the claim of "war on drugs," that is biased along gender, race and class characteristics, and offering possible reform to rectify the disparate impact).

139. As the *Harvard Mental Health Journal* noted:

Much of the early alarming research turned out to be seriously flawed. Evidence of the mothers' cocaine use (especially their own reports) were often unreliable, and the studies were not always controlled carefully. Testing for cocaine was not random, and often women were chosen for testing precisely because they seemed to be in need of help. Researchers had often neglected effects of poor nutrition and prenatal care, venereal disease, other drugs (especially alcohol, heroin, and tobacco), and above all, child neglect and abuse. It became apparent that journals had often been rejecting studies that contradicted the dominant view. A 1991 combined analysis of 20 studies on cocaine and pregnancy found few effects that could be specifically attributed to cocaine.

Update on Cocaine—Part I, 10 HARV. MENTAL HEALTH J. 1, 3 (1993).

140. For further information examining the fact that early studies were not supported by later ones, see, e.g., PHILLIP O. COFFIN, THE LINDESMITH CENTER, COCAINE & PREGNANCY (1997). In an article in the *Journal of the American Medical Association*, a team of research physicians condemned the inaccurate conclusions being drawn about the impact of maternal cocaine consumption on fetuses. Their meticulous and comprehensive review of the scientific data found that "available" evidence from the newborn period is far too slim and fragmented to allow any clear predictions about the effects of intrauterine exposure to cocaine on the course and outcome of child growth and development. See Linda Mayer, et al., *The Problem of Prenatal Cocaine Exposure: A Rush to Judgment*, 267 JAMA 406 (1992). In addition, the Center for Health Policy Research at George Washington University in a two-year study, "found a consensus among researchers that the negative consequences of *in utero* cocaine exposure were both temporary and treatable." GEORGE WASHINGTON CENTER FOR HEALTH POLICY RESEARCH, AN ANALYSIS OF RESOURCES TO AID DRUG-EXPOSED INFANTS AND THEIR FAMILIES (1993).

141. See Daniel R. Neuspiel, *Cocaine-Associated Abnormalities May Not Be Causally Related*, 146 AM. J. OF DISEASES OF CHILDREN 278 (1992); see also C.D. Coles, *Saying*

Further, carefully-controlled studies have found minimal or no increase in Sudden Infant Death Syndrome among infants prenatally exposed to cocaine¹⁴² and studies of chronic cocaine use among human and animal subjects have revealed "no direct effects on the health or development of newborns."¹⁴³ Most importantly, those medical professionals who work with cocaine-exposed children maintain that they are "indistinguishable from other children."¹⁴⁴ It

"Goodbye" to the "Crack Baby": Cocaine and the Fetus: Mythology of Severe Risk, 15 NEUROTOXICOLOGY AND TERATOLOGY 290 (1993) ("The hysteria and poorly considered reactions of both professionals and public have made the 'crack baby' for years an embarrassing episode."); Daniel R. Neuspiel, *Cocaine and the Fetus: Mythology of Severe Risk*, 15 NEUROTOXICOLOGY AND TERATOLOGY 305 (1993) (noting that the "mythology of severe risk" of gestational cocaine persists even though studies refute it). While some researchers have found an increase in genitourinary tract malformations and decreases in birth weights, body lengths, and head circumferences of cocaine-exposed neonates, they also note that the pregnant cocaine users studied have a clustering of other reproductive risk factors—notably, elevated tobacco and alcohol use and lack of prenatal care—that "confound" conclusions about cocaine toxicity. Researchers also observed that even problematic findings do not appear predictive of longer-term physiological, behavioral or cognitive deficits. See Jos et al., *supra* note 17, at 17.

142. See Coffin, *supra* note 140, at 21 (citing Howard Bauchner et al., *Risk of Sudden Infant Death Syndrome Among Infants with in Utero Exposure to Cocaine*, 113 J. PEDIATRICS 831–34 (1988)).

143. *Id.*; see also Ira J. Chasnoff, *Drug Use and Women: Establishing A Standard of Care*, 562 ANNALS OF THE N.Y. ACAD. OF SCI., 208–10 (1989), cited in Horger, *supra* note 29, at 527–31. In 1996, the Brown University School of Medicine studied the 1 and 2-day old infants of 57 women, 20 of whom smoked crack during pregnancy. The study revealed that while babies exposed to cocaine *in utero* were tense and jittery after hearing the sound of a rattle or bell, or alternatively lethargic and indifferent, there was no evidence that prenatal cocaine exposure cause hemorrhages, lesions, or other physical damage to infants' brains. See Christopher S. Wren, *For Crack Babies, a Future Less Bleak*, N.Y. TIMES, Sept. 22, 1998, at D4.

Moreover, Dr. Daniel R. Neuspiel, currently a pediatrician at Beth Israel Medical Center in New York, tracked 250 cocaine exposed infants for three to six years and found that although the newborns were irritable, had trouble eating and sleeping, and experienced an increased heart rate, these symptoms wore off after 72 hours. See *id.* He noted that his only consistent findings were in the growth of such infants, as they experienced reduced birth weight due to premature labor, and smaller head circumference. He concluded, however, that he had not observed any persistent problems related to prenatal cocaine exposure. See *id.*

144. See Dana Kennedy, *Experts: Children Born Addicted to Crack Rise Above Dire Predictions*, ASSOCIATED PRESS, Dec. 5, 1992, available in 1992 WL 5328389; see also Hallam Hurt et al., *Children With In Utero Cocaine Exposure Do Not Differ from Control Subjects on Intelligence Testing*, 151 ARCHIVES PEDIATRIC & ADOLESCENT MED. 1237 (1997) (finding that IQ scores did not differ between cocaine-exposed and non-cocaine-exposed children); Donald E. Hutchings, *The Puzzle of Cocaine's Effects Following Maternal Use During Pregnancy: Are There Reconcilable Differences?*, 15 NEUROTOXICOLOGY AND TERATOLOGY 281, 285 (1993) (finding that the growth and neurobehavioral effects attributable primarily to cocaine alone and not other substances of abuse appear to be only marginal and transitory); Gideon Koren, *Commentary, Cocaine and the Human Fetus: The Concept of Teratophilia*, 15 NEU-

comes then, as no surprise, that today even those same researchers responsible for igniting the political and media frenzy over "crack babies" maintain that the policies developed in response to the concern they manufactured have been more detrimental to infants and children than prenatal cocaine use.

Nevertheless, during the 1980's, tales of an ensuing onslaught of "crack babies" flooding urban hospitals were rampant and affected public as well as political and legal attitudes towards substance-dependency.¹⁴⁵ The misperceptions surrounding prenatal substance-addiction were so widespread that child welfare agencies across the nation had, and continue to have, difficulty locating homes for healthy children who were pejoratively labeled "crack babies."¹⁴⁶ Although physicians and medical researchers ultimately concluded that fears about the effects of prenatal cocaine use were vastly overblown, they were unable to effectively stem the tide of misinformation and alarm.¹⁴⁷

The Policy implementers' identification of cocaine addiction as posing the most significant risk to fetal health is further belied by the wealth of scientific evidence showing that lack of prenatal care¹⁴⁸ and

ROTOXICOLOGY AND TERATOLOGY 301, 303 (1993) (concluding that children of both social cocaine users and addictive cocaine users are likely to be normal both morphologically and neurodevelopmentally).

145. See Craig Reinerman & Harry G. Levine, *The Crack Attack: Politics and Media in American's Latest Drug Scare*, in IMAGES OF ISSUES: TYPIFYING CONTEMPORARY SOCIAL PROBLEMS 115 (Joel Best ed., 1989) (discussing the media's incentive to produce dramatic stories of the drug epidemic and politicians' use of these colorful exaggerations to motivate voters).

146. See Daniel R. Neuspiel, Letter, *Infant 'Abandonment' by Drug Using Mothers: Blaming the Victims?*, 148 ARCHIVES OF PEDIATRIC AND ADOLESCENT MEDICINE 437-438 (1994); Daniel R. Neuspiel et al., *Custody of Cocaine-Exposed Newborns: Determinants of Discharge Decisions*, 83 AM. J. PUB. HEALTH, 1726, 1726-29 (1993); J.C. Barden, *Foster Care System Reeling Despite Law Meant to Help*, N.Y. TIMES, Sept. 21, 1990, at A1 (showing the statistical growth of children placed in the foster care system and the declining pool of willing adoptive parents); Sandra Blakeslee, *Child-Rearing is Stormy When Drugs Cloud Birth*, N.Y. TIMES, May 19, 1990, at A1 (discussing the hardships encountered by adoptive parents in addition to difficulty finding doctors and baby sitters).

147. See Linda C. Mayes et al., *The Problem of Prenatal Cocaine Exposure: A Rush to Judgment*, 267 JAMA 406 (1992).

148. As Coffin noted, "The lack of quality prenatal care services is associated with prematurity, low birth weight, and other fetal developmental problems. Provision of quality prenatal care to heavy cocaine users (with or without drug treatment) has been shown to significantly improve fetal health and development." Coffin, *supra* note 140, at 2 (citing Luella Klein & Robert L. Goldenberg, *Prenatal Care and its Effect on Preterm Birth and Low Birth Weight*, in NEW PERSPECTIVES ON PRENATAL CARE 501, 525 (Irwin R. Merkatz & Joyce E. Thompson eds. 1990) (finding prenatal care plays an important role in reducing preterm birth and low birth weight)); see also Cynthia Chazotte et al., *Cocaine Use During Pregnancy and Low Birth Weight: The Impact of Prenatal Care and Drug Treatment*, 19 SEMINARS IN PERINATOLOGY 293, 293-94 (1995)

the use of tobacco¹⁴⁹ and alcohol¹⁵⁰ are the most significant causes of developmental problems in newborns. When compared to the primary causes of birth defects, including environmental agents (10–15%),¹⁵¹ heredity (10–15%),¹⁵² and those attributable to unknown factors,¹⁵³ chemical exposure accounts for only a tiny percentage of all birth defects (1–5%).¹⁵⁴ Yet, despite the greater threat posed by

(finding a lower rate of low birth weight among cocaine-using women who received prenatal care compared with those who did not receive prenatal care); Scott N. MacGregor et al., *Cocaine Abuse During Pregnancy: Correlation Between Prenatal Care and Perinatal Outcome*, 74 OBSTETRICS AND GYNECOLOGY 882, 885 (1989) (concluding that comprehensive prenatal care may improve the outcome in pregnancies complicated by cocaine abuse, but prenatal morbidity associated with cocaine abuse cannot be eliminated by improved prenatal care).

149. See Coffin, *supra* note 140, at 2 (“Tobacco use is associated with low birth weight, prematurity, growth retardation, SIDS, cognitive, achievement, and behavioral problems, and, in rare cases, mental retardation.”) (citations omitted). A study conducted by Drs. DiFranza and Lew found that

[e]ach year, use of tobacco products is responsible for an estimated 19,000 to 141,000 tobacco-induced abortions, 32,000 to 61,000 infants born with low birthweight, and 14,000 to 26,000 infants who require admission to neonatal intensive care units. Tobacco use is also annually responsible for an estimated 1900 to 4800 infant deaths resulting from perinatal disorders, and 1200 to 2200 deaths from sudden infant death syndrome (SIDS).

Joseph R. DiFranza & Robert A. Lew, *Effect of Maternal Cigarette Smoking on Pregnancy Complications and Sudden Infant Death Syndrome*, 40 J. FAMILY PRACTICE 385, 385 (1995). Researchers have found that the fetal effects of paternal and maternal cigarette smoking are strikingly similar to those of prenatal cocaine exposure. See GEORGE WASHINGTON UNIV. CTR. FOR HEALTH POLICY RESEARCH, AN ANALYSIS OF RESOURCES TO AID DRUG-EXPOSED INFANTS AND THEIR FAMILIES 3 (1993) (citing J.J. Volpe, *Mechanisms of Disease: Effects of Codeine Use on the Fetus*, 327 NEW ENGL. J. MED. 399 (1992)); K.C. Schoendorf & J.L. Kiely, *Relationship of Sudden Infant Death Syndrome to Maternal Smoking During and After Pregnancy*, 90 PEDIATRICS 905 (1992); D.L. Davis, *Paternal Smoking and Fetal Health*, 337 LANCET 123 (1991). Notwithstanding these facts, there have been no reported attempts to arrest or prosecute cigarette smoking parents for prenatal harm.

150. See Coffin, *supra* note 140, at 2 (“Abuse of alcohol, more than any recreational drug, causes the greatest number of and most severe birth defects: 0.19% of all newborns (about 7600, or 1% of all newborns exposed to alcohol) are diagnosed with Fetal Alcohol Syndrome, and a larger number experience ‘fetal alcohol effects.’”). It is estimated that 1 in 600 infants are born every year with permanently debilitating conditions related to fetal alcohol syndrome. In fact, fetal alcohol syndrome is the leading known cause of mental retardation. See Roberts, *supra* note 105, at 177.

151. See Coffin, *supra* note 140, at 2 (citing Donald E. Hutchings, *Prenatal Opioid Exposure and the Problem of Causal Inference*, in CURRENT RESEARCH ON THE CONSEQUENCES OF MATERNAL DRUG ABUSE 6, 17 (1985)).

152. See *id.*

153. See Nora S. Gustavsson, *Drug Exposed Infants and Their Mothers: Facts, Myths and Needs*, 16 SOC. WORK HEALTH CARE, 87, 96 (1992).

154. See Coffin, *supra* note 140, at 2.

other behavior and characteristics, MUSC continued its preexisting policies with respect to all factors except cocaine.

Prior to October 1989, MUSC personnel reported to DSS the use by pregnant women of many different drugs, including alcohol.¹⁵⁵ MUSC staff had also previously used civil commitment proceedings instead of criminal incarceration for alcoholic patients or those addicted to drugs such as cocaine.¹⁵⁶ While MUSC continued this practice for women whom it found were addicted to alcohol or other illegal substances, after the Policy was adopted cocaine addicts were reported to law enforcement officials and arrested.¹⁵⁷

Many activities, both legal and illegal, can detrimentally affect fetal health and development. Exposure to environmental factors such as inadequate nutrition or sexually transmitted diseases, exposure to occupational hazards, substandard housing, and lack of social supports and services can have profound negative affects on infant health.¹⁵⁸ Other potential hazards include physical and psychosocial stress which may contribute to low birth weight. In addition, medical risks predating pregnancy such as diabetes and chronic hypertension, and medical risks during pregnancy such as carrying multiple fetuses and even being pregnant while under the age of seventeen or over the age of thirty-four, can have adverse effects on a fetus.¹⁵⁹ Indeed, "even large doses of aspirin may delay the onset of labor and cause premature closure of the fetal ductus arteriosus . . . or neonatal bleeding."¹⁶⁰ If the idea behind the Policy was followed to its logical conclusion, then any pregnant woman who drinks alcohol could be arrested for child abuse because of the risk of fetal alcohol syndrome. Similarly, a pregnant woman could be arrested for failing to take proper

155. See Brief of Appellants, *supra* note 3, at 9.

156. See JA, *supra* note 5, at 1150-52, noted in Brief of Appellants, *supra* note 3, at 29-30.

157. See JA, *supra* note 5, at 768, 1224, 1319-20, noted in Brief of Appellants, *supra* note 3, at 30.

158. See Amicus Curiae Brief of the Lindesmith Center and Women's Law Project, *Whitner v. South Carolina*, 492 S.E.2d 777 (S.C. 1997), cert. denied, 118 S. Ct. 1857 (1998), reprinted in 9 HASTINGS WOMEN'S L.J. 139, 146-47 (1998) [hereinafter Lindesmith Center Amicus Brief] (citing N.S. Gustavson & A.E. Mac Eachron, *Criminalizing Women's Behavior*, 27 J. OF DRUG ISSUES 673, 675-76 (1997)); see also COMMITTEE ON LOW BIRTHWEIGHT, *supra* note 137, at 1-7.

159. See Lindesmith Center Amicus Brief, *supra* note 158, at 145-47.

160. THE MERCK MANUAL OF DIAGNOSIS AND THERAPY § 18, ch. 249 (Mark H. Beers & Robert Berkow eds., 17th ed. 1999), quoted in Lindesmith Center Amicus Brief, *supra* note 158, at 146. Many commonly prescribed medications, such as anticonvulsants, lithium, and other mood stabilizers, antipsychotics, and benzodiazepines (class of medications which includes Valium, Librium and Xanax), some antibacterials (especially Tetracyclines), anticoagulants, thyroid medications, and antihypertensive drugs, can be dangerous to fetuses. See Lindesmith Center Amicus Brief, *supra*, at 145-46.

medication, or failing to follow her doctor's orders. Failing to refrain from rigorous sports during pregnancy could likewise lead to criminal sanctions. Moreover, a woman could be prosecuted for potentially damaging her fetus by smoking cigarettes during pregnancy. Thus, by necessary implication, prenatal exposure to any substance, activity or factor demonstrated to have a detrimental affect would constitute child abuse.¹⁶¹

B. The Policy Evinced Discriminatory Intent To Target Poor Black Women

From October 1989 to January 1990, those women who tested positive for cocaine at the time they gave birth were not afforded the opportunity to receive treatment for substance-dependency, but were arrested immediately based on the single drug test.¹⁶² Even those women who sought prenatal care prior to labor and delivery at MUSC were not given the opportunity to receive treatment. Instead, many of these women were simply arrested.¹⁶³ Pursuant to the Policy, depending on the stage in the pregnancy when cocaine use was discovered, women who tested positive could be arrested or threatened with arrest for crimes such as possession of drugs, child neglect, or distribution of drugs to a person under the age of eighteen.¹⁶⁴ The

161. See *Tolliver v. South Carolina*, 90-CP-23-5178 (Cir. Ct., Manning County, S.C. 1992); see also *Stallman v. Youngquist*, 531 N.E.2d 335, 359 (Ill. 1988) ("Since anything which a pregnant woman does or does not do may have an impact, either positive or negative, on her developing fetus, any act or omission on her part could render her [criminally] liable to her subsequently born child.").

162. See JA, *supra* note 5, at 325, 348-49, 590-93, 1267, 1427, noted in Brief of Appellants, *supra* note 3, at 17.

163. The women who tested positive for drug use received no referral for drug treatment nor an opportunity to seek treatment as an alternative to arrest. Indeed, one woman arrested under the Policy repeatedly requested help in obtaining drug treatment. See JA, *supra* note 5, at 1843-44; Brief of Appellants, *supra* note 3, at 17. At trial, this woman explained, "I asked, please, what could I do to stop this or could you help me, I mean, because, you know, what is going on. And then [the Nurse] just said you will be locked up." JA, *supra* note 5, at 325, quoted in Brief of Appellants, *supra* note 3, at 17-18.

164. See Brief of Appellants, *supra* note 3, at 16. The women targeted could be charged with unlawful conduct towards a child, a felony carrying a maximum sentence of ten years. See S.C. CODE ANN. § 20-7-50 (West Supp. 1998). If it was a woman's first offense, she could be charged with possession of cocaine, a misdemeanor carrying a maximum two year sentence. See *id.* § 44-53-370(c) (1) (West Supp. 1998). Cocaine is listed as a Schedule II drug in South Carolina, see S.C. CODE ANN. § 44-53-210(b) (4) (Law Co-op 1985), which means that she could also be charged with distribution of crack cocaine to a person under age eighteen and would then face a maximum sentence of twenty years in prison. See S.C. CODE ANN. § 44-53-440 (Law Co-op 1985 & West Supp. 1998).

Policy was applied to all phases of pregnancy, both before and after fetal viability.¹⁶⁵

Close examination of many aspects of the Policy's implementation reveals that it was intended to focus exclusively on indigent Black women. For instance, the application and enforcement of the Policy deviated from MUSC's standard medical practice with regard to consent to drug searches and patient confidentiality in medical matters. MUSC personnel, including a manager who openly espoused racist beliefs, maintained substantial discretion over the testing and reporting of women. Further, for reasons of political expediency, the solicitors largely responsible for the Policy's creation chose to test and target women they considered essentially powerless.

1. MUSC Personnel

MUSC staff were afforded an unusually wide degree of discretion in applying the Policy and were integral to facilitating the arrests. Throughout the period the Policy was enforced, MUSC health care workers would call the CPD, file complaints, inform the police that a patient who had tested positive was about to leave the hospital, and help the CPD coordinate the patient's in-hospital arrest.¹⁶⁶ Without doubt, granting unfettered discretion to health care workers in deciding whom to test merely facilitated the Policy's racially disparate effects.

Actions taken by the Nurse, a White woman who was in large part responsible for the creation of the Policy, suggest that she harbored blatantly racist beliefs.¹⁶⁷ Described as the Policy "point person," the Nurse openly maintained that the problems of cocaine abuse and addiction were unique to the Black community and pushed for adoption of the Policy to address "an epidemic among pregnant black women."¹⁶⁸ Other workers testified that the Nurse frequently expressed her view that Black patients, to the exclusion of all others, should be sterilized, and she testified in court that she thought that "mixing of the races is against God's way."¹⁶⁹ Indeed, if she learned that the father of a White patient's baby was Black, she

165. See JA, *supra* note 5, at 1425, noted in Brief of Appellants, *supra* note 3, at 16-17.

166. See JA, *supra* note 5, at 1269-70, noted in Brief of Appellants, *supra* note 3, at 17-18. Although she did not occupy a management position, the Nurse not only dictated which patients were to be tested, but performed tasks on behalf of the Solicitor's Office. See Brief of Appellants, *supra* note 3, at 29.

167. See Brief of Appellants, *supra* note 3, at 30-31.

168. JA, *supra* note 5, at 1396, quoted in Brief of Appellants, *supra* note 3, at 31.

169. Brief of Appellants, *supra* note 3, at 31.

routinely noted this fact on the patient's medical record,¹⁷⁰ even though the race of the infant's father was irrelevant to the information needed by medical personnel.¹⁷¹ The Nurse enjoyed a wide range of powers, as the ability to identify, test and distinguish particular women to the authorities rested within her direct control.

2. The Charleston Solicitors

The Charleston solicitors' response to the grossly exaggerated reports of the effects of cocaine on fetuses did not reflect recent medical developments, but were instead based on popular notions of "crack babies" and "bad mothers"—stereotypes which provided substantial political currency. While the original Policy was publicly endorsed by both candidates in the 1994 race for attorney general in South Carolina, the solicitor who was most closely identified with the Policy and was influential in its creation and implementation was ultimately elected by a wide margin.¹⁷²

The representative from the Solicitor's Office, as Policy framers, interjected their primarily White, affluent, male norms into the Policy's creation using their vast latitude in implementing the Policy to target those most different from themselves. While the solicitors maintained unbridled and substantially unreviewable discretion to prosecute all, any or no substance-dependent women, they singled out Black women for their "choice" to use drugs while pregnant. Distorting legislative intent by expanding the coverage of South Carolina's general child abuse and neglect statutes to cover Black women who became pregnant while substance-addicted,¹⁷³ the

170. See JA, *supra* note 5, at 722-24, 1460, 1488, 1489, 1491, noted in Brief of Appellants, *supra* note 3, at 31. On one patient's medical records, the Nurse wrote, "Pt. Lives with her boyfriend who is a Negro." For another, she wrote, "Pt. States that FoB is black." In still another she wrote, "Boyfriend black," double underlining "black." *Id.*

171. See JA, *supra* note 5, at 722-24; Brief of Appellants, *supra* note 3, at 31.

172. See Jos et al., *supra* note 17, at 126.

173. Circuit Court Judge Thomas W. Cooper observed that:

When the legislature has meant fetus, it has used the word "fetus" to the exclusion of the word "child." See, e.g., Code of Laws § 44-41-10(f) (defining pregnancy as "the condition of a woman carrying a fetus or embryo with in her body as the result of conception.") and (1) (defining viability as "that stage of human development when the fetus is potentially able to live outside of the mother's womb with or without the aid of artificial life support systems."). Thus, the legislature has clearly used fetus when it meant fetus. This court can only conclude that the legislature consciously chose to use the word "child" in § 20-7-60 to the exclusion of the word "fetus."

solicitors went after those individuals who wielded the least power and influence in society—those who represented an affront to middle-class moral standards.

By criminalizing the addiction status of substance-dependent, pregnant, Black women, the creators of the Policy relied on the fact that Americans have been socialized to accept the notion that a portion of the population is less valuable and less worthy of public concern and therefore more deserving of punishment.¹⁷⁴ By conflating issues of race, crime, class and gender, the solicitors were effectively able to exploit the internalized racism and misogyny that permeates the American collective consciousness,¹⁷⁵ and thereby evoke both the Jezebel and Breeder Woman archetypes—the wanton, depraved Black temptress with the uncontrollable libido, and the Black mother irresponsibly and selfishly bearing children. Utilizing these politically potent symbols laden with negative historical and culturally specific meaning, the solicitors were able to garner and maintain support for the Policy. One of the two solicitors responsible for the development and implementation of the Policy candidly explained, “[t]here’s not enough political will to move after pregnant women who use alcohol or cigarettes. There is, though, a political basis for this Interagency Program.”¹⁷⁶

Tolliver v. South Carolina, 90-CP-23-5178 (Cir. Ct., Manning County, S.C. 1992); see also Charles Lawrence, *The Id, the Ego and Equal Protection: Reckoning with Unconscious Racism*, 39 STAN. L. REV. 317 (1987) (arguing that unconscious and unintended racism is ignored in the intent requirement of the Equal Protection Clause).

174. In response to the suggestion that more be done to help these women and their children, one solicitor cried: “These women want day care and free transportation, but who’s taking care of their kids when they’re on coke?” He further accused the women of “blam[ing] society,” rather than assuming their personal responsibility for their problems. Jos et al., *supra* note 17, at 126.

175. While the blatantly racist beliefs that supported the institutions of slavery and Jim Crow are much less prevalent today, American society remains infected with a less obvious but in many ways more insidious “laissez-faire” racism. See Lawrence D. Bobo, *The Color Line, the Dilemma, and the Dream: Race Relations in America at the Close of the Twentieth Century*, in CIVIL RIGHTS AND SOCIAL WRONGS: BLACK-WHITE RELATIONS SINCE WORLD WAR II 31, 38 (J. Higham ed., 1997). According to a 1990 study of racial attitudes, White people identified Blacks as more likely than themselves to be unpatriotic, prone to violence, unintelligent, and lazy, preferring to receive welfare benefits rather than work. See *id.* at 38–40. These pervasive, often unconscious, yet deeply held beliefs form the basis for broad support among White Americans of measures that have a disparate negative impact on Black people. Some examples of this phenomena include recent anti-affirmative action measures and the passage of punitive welfare reform legislation. Moreover, while pregnant women who consume alcohol are subject to some level of social stigma, they are not subject to criminal sanctions like pregnant women who smoke crack. The fact that alcohol is legal and crack is not is largely attributable to the fact that many more White women drink alcohol than smoke crack. Hence society has established other, noncriminal, means by which to contend with these women and any harm caused to their fetuses.

176. Jos et al., *supra* note 17, at 124.

Armed with the power to educate the public about the primary causes of substance-addiction as well as the ability to help increase the availability of treatment for those in need, the Policy framers instead exploited the public's outrage over a perceived violation of accepted moral norms.¹⁷⁷ In so doing, MUSC and the solicitors adopted a policy that directly and egregiously undermined the social, health and psychological conditions of pregnant Black women and their children.

3. No Search Warrants or Consent to Searches

The Policy violated MUSC's own standards on informed consent,¹⁷⁸ patients' rights to privacy and confidentiality in medical matters, and the right to refuse medical treatment.¹⁷⁹ Medical patients' right to informed consent and the concomitant right to refuse medical treatment are fundamental and well established tenets in both American legal doctrine and biomedical standards. Health care providers and their patients share a fiduciary relationship which imposes upon providers an affirmative duty to maintain the confidentiality of their patients. To this end, health care providers are charged with safeguarding their patients' right to control the release of private medical information, including information on their health status and treatment. When this bond of trust is broken, the therapeutic relationship between patients and health care providers is detrimentally and often irreversibly affected.

While the Policy required women who wished to obtain treatment at MUSC's obstetric clinic to sign a form consenting to medical treatment, including a urine toxicology screen,¹⁸⁰ no attempt was made in these forms to obtain the patient's consent or authorization

177. See Craig Reinerman & Harry G. Levine, *The Crack Attack: Politics and Media in the Crack Scare*, in *CRACK IN AMERICA* 18, 23 (Craig Reinerman & Harry G. Levine, eds., 1997). Many Americans bought into the inflammatory media coverage of and political response to the rise in the use of crack cocaine during the late 1980's. Indeed, crack and other illegal drugs were depicted as "virulent diseases that were attacking American society." Craig Reinerman & Harry G. Levine, *Crack in Context: America's Latest Demon Drug*, in *CRACK IN AMERICA*, *supra*, at 1, 3.

178. See *id.*; JA, *supra* note 5, at 1442-443, 873 (noting that MUSC's general counsel admitted that the consent forms might be inadequate. This was confirmed by the trial court, which held that the Hospital's two general consent forms were "not sufficient to warrant a search where the search information [was] furnished to law enforcement officers.").

179. See JA, *supra* note 5, at 1481, *quoted in* Brief of Appellants, *supra* note 3, at 10 n.10 (noting that according to MUSC's Patient Handbook, "medical records and all communication pertaining to [the patient's] care are also treated as confidential").

180. See MICH REPORT VOL. III, *supra* note 30, at 25-26.

to the disclosure of the information to the police department.¹⁸¹ Neither the Solicitor's Office nor the CPD obtained search warrants, subpoenas or court orders prior to the collection and search of a pregnant woman's urine for drugs.¹⁸²

MUSC's consent forms were constitutionally inadequate since they authorized only "Medical Treatment" and sanctioned drug testing "deemed advisable by [a] physician," and release of information only as "required in the processing of applications for financial coverage for services rendered."¹⁸³ While MUSC's Consent to Ambulatory Care form allowed for consent to drug testing provided it was "deemed advisable by or necessary in the professional judgment of the physician" and afforded the "attending Physician" "permission" "to reveal information to appropriate agencies and individuals,"¹⁸⁴ it is difficult to imagine that the women targeted under the Policy understood that "appropriate agencies and individuals" were law enforcement authorities, not health care personnel. This is particularly so in light of the fact that the drug testing was addressed within the context of a "Consent to Ambulatory Care" form.¹⁸⁵

None of the other paper work related to the Policy sought the patient's consent or authorization, and a letter regarding the Policy was provided to the patient only after she had been drug screened.¹⁸⁶ The patient's signature on the letter was used only to acknowledge that she had received it, according to the testimony of an Assistant Solicitor.¹⁸⁷ Despite the fact that all patients receiving prenatal care at MUSC were to be provided a letter indicating that they might be screened for drugs, this was not the case. The letter itself stated:

If however, we *continue to detect evidence of drug abuse* or a failure to follow recommended treatment, we will take action to protect your unborn child. The Charleston Police, the Solicitor's Office, and the Protective Services Division of the DSS are also committed to the protection

181. See JA, *supra* note 5, at 1443; Brief of Appellants, *supra* note 3, at 11.

182. See Brief of Appellants, *supra* note 3, at 14.

183. See JA, *supra* note 5, at 1442, *noted in* Brief of Appellants, *supra* note 3, at 10–11.

184. See Brief of Appellants, *supra* note 3, at 11.

185. See, e.g., *United States v. Attson*, 900 F.2d 1427, 1429 (9th Cir. 1990) (upholding the distinction between the taking of blood for medical purposes and the taking of blood for police use).

186. See JA, *supra* note 5, at 603, 1199–1200, 1432–34, *noted in* Brief of Appellants, *supra* note 3, at 11 (letters stated "[d]uring your recent examination you tested positive for drugs").

187. See Brief of Appellants, *supra* note 3, at 11.

of unborn and newborn children from the harms of illegal drug abuse.¹⁸⁸

Thus, the women were informed only after they had been screened. Moreover, the letter did not disclose that the urine drug screens were conducted for law enforcement purposes or that confidential medical information procured in this manner would be revealed to the CPD.

The drug screens performed on those patients identified pursuant to the subjective criteria delineated in the protocol constituted searches within the meaning of the Fourth Amendment, and thus required either a warrant based on reasonable suspicion or consent.¹⁸⁹ A search conducted without a warrant issued upon probable cause is "*per se* unreasonable subject only to a few specifically established and well-delineated exceptions."¹⁹⁰ When consent is used to justify the lawfulness of a search, it must be proven that consent was not only given, but given "freely and voluntarily"¹⁹¹ and was not the result of express or implied duress or coercion.¹⁹² Accordingly, the United States Supreme Court has maintained that a search conducted "by stealth" is not consensual, but is "against the will of the person searched" and thus does not pass constitutional muster.¹⁹³ Consent is absent even when one agrees to a search, fully aware that the search is being conducted for law enforcement purposes, if the search is used for a different law enforcement purpose than the one

188. JA, *supra* note 5, at 1437, quoted in Brief of Appellants, *supra* note 3, at 12.

189. See, e.g., *Chandler v. Miller*, 520 U.S. 305, 313 (1997) (finding that Georgia's drug testing requirement for candidates for designated state offices "effects a search within the meaning of the Fourth and Fourteenth Amendments"). The Fourth Amendment states that "[t]he right of the people to be secure in their persons, houses, papers, and effects, against unreasonable searches and seizures, shall not be violated, and no Warrants shall issue, but upon probable cause, supported by Oath or affirmation, and particularly describing the place to be searched, and the persons or things to be seized." U.S. CONST. amend. IV.

190. *Schneckloth v. Bustamonte*, 412 U.S. 218, 219 (1973) (citations omitted).

191. See *id.* at 222.

192. See *id.* at 248; see also *Gorman v. United States*, 380 F.2d 158, 163 (1st Cir. 1967) (stating that consent must be "unequivocal, specific and intelligently given, uncontaminated by any duress or coercion.") (citation omitted).

193. See *Gouled v. United States*, 255 U.S. 298, 305-06 (1921) (holding that the Fourth Amendment is violated when a man is granted entry into a suspect's house by falsely representing that he intended to pay a social visit, and then goes through and seizes the suspect's private papers); see also *United States v. Tweel*, 550 F.2d 297, 299 (5th Cir. 1977) (holding that where an IRS agent failed to disclose the criminal nature of an audit, he engaged in "a sneaky deliberate deception . . . and a flagrant disregard for appellant's rights [and that] the silent misrepresentation was both intentionally misleading and material").

disclosed.¹⁹⁴ And, consent to “administrative”¹⁹⁵ rather than “criminal” searches must still be knowingly obtained.¹⁹⁶

Consultation with a health care provider for a specific purpose does not constitute a general consent to investigate unrelated medical conditions. This is true regardless of whether or not the investigation involved a physically noninvasive urine test. Health care providers are required to follow informed consent processes, including disclosure, voluntariness and patient comprehension. They must also respect a patient’s right to refuse treatment, which can be overridden only in those instances when the patient is incapable of making the decision or when the patient poses a threat to herself or others.¹⁹⁷ Thus, the relationship is one based on the patient’s confidence that her healthcare provider will both protect her interests and remain committed to her “well being.” Breaches of confidentiality, medical coercion and punitive incarceration undermine trust, which in turn keeps patients from seeking necessary care.¹⁹⁸

194. See *Graves v. Beto*, 424 F.2d 524, 525 (5th Cir. 1970) (holding a search inadmissible where police officer requested blood sample from drunken suspect to determine its alcohol content, without indicating that the suspect was under suspicion of rape).

195. Administrative searches are subject to a lower standard of Fourth Amendment protection. See, e.g., *Skinner v. Railway Labor Executives’ Ass’n*, 489 U.S. 602, 634 (1989) (upholding the reasonableness of federal regulation requiring blood and urine drug tests of rail employees involved in train accidents).

196. Compare *Anable v. Ford*, 653 F. Supp. 22, 37 (W.D. Ark. 1985) (holding that student’s consent to breathalyzer was valid where student “was fully aware of his options before taking the test and knowingly agreed to take it because he thought that he could ‘pass’ it”) with *Anable v. Ford*, 663 F. Supp. 149, 152 (W.D. Ark. 1985) (holding student’s consent was insufficient because she was not fully informed and was misled).

197. See *Jos et al.*, *supra* note 17, at 123.

198. This fact is so uncontroverted that in 1972 the U.S. Congress enacted legislation directly addressing this truth. See 42 U.S.C. § 290dd-2 (Supp. I 1999). This legislation specifically prohibits the disclosure of patients’ records by drug programs and especially for use to substantiate or initiate any criminal charge. Indeed, Congress, in the Congressional Conference Report issued in connection with 21 U.S.C. § 1175, the statutory predecessor to 42 U.S.C. § 290dd-2, explicitly acknowledged that public disclosure of a patient’s addiction status jeopardizes rehabilitation efforts:

The conferees wish to stress their conviction that the strictest adherence to the provisions of this section is absolutely essential to the success of all drug abuse prevention programs. Every patient and former patient must be assured that his right to privacy will be protected. Without that assurance, fear of public disclosure of drug abuse or of records that will attach for life will discourage thousands from seeking the treatment they must have if this tragic national problem is to be overcome.

4. Violation of Patient Confidentiality

The criminalization of prenatal drug addiction forces health care providers to breach patient confidentiality when it is most critically needed. Patients must provide accurate information about substance-addiction to their medical providers in order to ensure that they receive proper prenatal care.¹⁹⁹ Deputizing health care providers as law enforcement officials undermines this goal by creating a strong incentive for a substance-dependent patient to withhold information crucial to her care and that of the child she carries.²⁰⁰

H.R. CONF. REP. NO. 92-920, 33 (1972), *reprinted in* 1972 U.S.C.C.A.N. 2045, 2072, *quoted in* Commissioner of Social Services v. David R.S., 436 N.E.2d 451, 454 n.4 (1982) (reversing order to disclose drug abuse treatment records in paternity proceedings); *see also* Local 738 Int'l Bhd. of Teamsters v. Certified Grocers Midwest, Inc., 737 F. Supp. 1030 (N.D.Ill. 1990) (denying enforcement of arbitration subpoena seeking disclosure of patient drug abuse treatment records).

199. As one text noted:

To make diagnoses and treat patients effectively, the physician must obtain sensitive information about a patient. A patient must be willing to tell a physician, who is often a total stranger, about such matters as drug usage . . . and to allow the physician to examine intimate parts of his or her anatomy. The promise of confidentiality encourages patients to disclose sensitive subjects to a physician without fear that an embarrassing condition will be revealed to unauthorized people. Violation of confidentiality also shows disrespect to the patient as a human being. . . .

R. Arnold et al., *Medical Ethics and Doctor/Patient Communication*, in *THE MEDICAL INTERVIEW: CLINICAL CARE, EDUCATION AND RESEARCH* 345, 365 (M. Lipkin, Jr. et al. eds., 1995) (citation omitted).

200. In a series of interviews conducted with women who used drugs while pregnant, the General Accounting Office ("GAO") sought information on these women's "views and experiences on barriers that prevented them, or women they knew, from receiving drug treatment." *See* GENERAL ACCOUNTING OFFICE, ADMS BLOCK GRANT: WOMEN'S SET-ASIDE DOES NOT ASSURE DRUG TREATMENT FOR PREGNANT WOMEN 4 (1991) [hereinafter ADMS BLOCK GRANT]. The GAO concluded that "[t]he threat of prosecution poses yet another barrier to treatment for pregnant women and mothers with young children." *Id.*

Indeed, according to the Institute of Medicine:

Pregnant women who are aware that their life-styles place their health and that of their babies at risk may also fear seeking care because they anticipate sanction or pressure to change such habits as drugs and alcohol abuse, heavy smoking, and eating disorders. Substance abusers in particular may delay care because of the stress and disorganization that often surrounds their lives, and because they fear that if their use of drugs is uncovered, they will be arrested and their other children taken into custody.

Brief of the American Public Health Association et al. as *Amici Curiae* in Support of Respondent at 9, *Whitner v. South Carolina*, 492 S.E.2d 777 (S.C. 1997) [hereinafter *Whitner Amicus Brief*] (citing INSTITUTE OF MEDICINE, *PRENATAL CARE* 79 (1988)).

An environment of trust and communication is a necessary component of any effort to reduce or prevent harm to infants exposed to drugs prenatally.²⁰¹ This can, in fact, significantly reduce the harm to a woman and her child in several ways. For example, a patient's drug use is seldom apparent unless the patient discloses it, as drug use is currently the most commonly missed diagnosis in obstetric and pediatric medicine.²⁰² Thus, the patient and her child are far better off if she trusts her health care provider and is willing to divulge extremely personal, often stigmatizing, and possibly incriminating information.²⁰³ Yet, even if the patient is unable to overcome her addiction, potential dangerous health consequences can be mitigated or reduced through adequate prenatal care and counseling.²⁰⁴

In addition, open communication with physicians regarding drug use is necessary to ensure safe deliveries.²⁰⁵ Adequate parenting skills and a supportive environment fostered by a committed partnership with health care providers can minimize risk factors caused by prenatal drug exposure.²⁰⁶ Comprehensive studies of deterrents to prenatal care have concluded that women are less likely to seek such care "if they have had unpleasant experiences with providers."²⁰⁷ To be sure, knowledge that discovery of maternal drug use will lead to

201. See Lindesmith Center Amicus Brief, *supra* note 158, at 148; see also M.J. Kreek & M. Reisinger, *The Addict as a Patient*, in COMPREHENSIVE TEXTBOOK 822, 830 ("It is quite clear that part of treating [a substance-addicted individual] as a patient includes embracing all of the appropriate ethical constraints of health care delivery Possibly at the top of the list of ethical issues that are of very special and fundamental importance to this group of patients is the appropriate maintenance of confidentiality."); R. Elk et al., *Behavioral Interventions: Effective and Adaptable for the Treatment of Pregnant Cocaine-Dependent Women*, 27 J. OF DRUG ISSUES 627, 630 & 632 (1997) ("Confidentiality must be rigidly adhered to and a trust in the staff established: to attract to and retain in treatment pregnant drug-dependent women."); NATIONAL COUNCIL ON ALCOHOLISM AND DRUG DEP., POLICY STATEMENT, WOMEN, ALCOHOL, OTHER DRUGS AND PREGNANCY 5 (1990) ("States should resist efforts to weaken confidentiality protections for pregnant alcoholic and other drug-dependent women seeking prenatal care or alcoholism and/or drug treatment services.").

202. See Ira J. Chasnoff, *Drug Use in Pregnancy: Parameters of Risk*, 35 PEDIATRIC CLINICS OF NORTH AM. 1403, 1410 (1988).

203. See Lindesmith Center Amicus Brief, *supra* note 158, at 148.

204. See *id.*

205. See *id.* (citing David J. Birnbach et al., *Cocaine Screening of Parturients Without Prenatal Care: An Evaluation of a Rapid Screening Assay*, 84 ANESTHESIA & ANALGESIA 76, 76 (1997)) (stating that patients using cocaine may have untoward responses to anesthesia, yet identification of such patients prior to the initiation of anesthesia has proven difficult since many patients deny illicit drug use).

206. See Lindesmith Center Amicus Brief, *supra* note 158, at 148.

207. STATE COUNCIL ON MATERNAL, INFANT AND CHILD HEALTH, OFFICE OF THE GOVERNOR, 2 1991 SOUTH CAROLINA STUDY OF DRUG USE AMONG WOMEN GIVING BIRTH: PREVENTION AND TREATMENT SERVICES 7 (Feb. 1992) [hereinafter MICH REPORT VOL. II].

arrest and prosecution could be classified as an "unpleasant experience."²⁰⁸

The women subjected to the Policy were unaware that MUSC's confidentiality requirements did not apply to the results of their urine tests. In fact, MUSC's Patient Handbook, shown to all who came to the hospital for care, stated that "medical records and all communications pertaining to your care are also treated as confidential."²⁰⁹ In the private obstetrics department, for example, patient confidentiality was maintained and patient records were held in confidence unless written permission to release them was obtained.²¹⁰

Most of the women arrested under the Policy said that they assumed that they would be helped, not arrested, if they went to the hospital for care.²¹¹ The women did not know that their medical providers would disclose information about their drug addiction to the police.²¹² Even those women who had an idea that drug use during pregnancy might be considered illegal believed that their physicians and hospital personnel would aid them in obtaining help for their addiction, and were stunned by the discovery that their health care providers were working in conjunction with the police.

The results of the urinalysis along with other confidential medical information were disclosed to the Solicitor's Office or the CPD, despite MUSC's lack of authority to do so.²¹³ Urine tests that indicated cocaine use were recorded in the patient's medical chart and on Rolodex cards maintained by the Nurse in her office.²¹⁴ Positive

208. See Whitner Amicus Brief, *supra* note 200, at 9–10. A Detroit study of 142 women to determine the effects of threats of punitive action by medical providers on maternal drug use concluded that substance-addicted pregnant women would likely go underground and avoid medical treatment for fear of incarceration and loss of their children. See Marilyn L. Poland et al., *Punishing Pregnant Drug Users: Enhancing the Flight from Care*, 31 *DRUG AND ALCOHOL DEPENDENCE* 199, 202 (1993). Moreover, the same research team which conducted this study attempted to duplicate the study in another state where prosecutors were threatening incarceration for prenatal drug addiction, but were unable to find participants since all known drug addicted post-partum women refused to participate for fear of further self-incrimination. See *id.* at 202.

209. JA, *supra* note 5, at 1481, *quoted in* Brief of Appellants, *supra* note 3, at 10 n.10.

210. See Brief of Appellants, *supra* note 3, at 9.

211. See JA, *supra* note 5, at 380, *noted in* Brief of Appellants, *supra* note 3, at 14.

212. See JA, *supra* note 5, at 199, 244; Brief of Appellants, *supra* note 3, at 14.

213. See JA, *supra* note 5, at 199, 244, 322; Brief of Appellants, *supra* note 3, at 10. MUSC had also collected such private information as the patient's medical history, incidence of sexually transmitted diseases, sterilization procedures done while in the hospital, HIV status, and any past abortions. All of this information was disclosed to the CPD officer who came to the hospital to arrest the patient. See Brief of Appellants, *supra* note 3, at 14–15.

214. See JA, *supra* note 5, at 609–10, *noted in* Brief of Appellants, *supra* note 3, at 14.

results were provided to the Solicitor's Office and, in some circumstances, to the CPD.²¹⁵ Solicitor's Office personnel, in fact, had access to the Rolodex and files kept in the Nurse's office.²¹⁶

Those patients who tested positive were traced in accordance with the Suspected Child Abuse and Neglect ("SCAN") meetings at which MUSC personnel, the DSS, the Solicitor's Office and the CPD discussed suspected child abuse.²¹⁷ Prior to each meeting, confidential information on each patient to be discussed, including HIV status and information on tubal ligations, was sent to all those who were to attend the SCAN meeting.

With the information provided by MUSC personnel, the CPD would go to the hospital to arrest those identified. No referrals to drug treatment programs were provided to these women, nor were they given the opportunity to obtain treatment as an alternative to arrest.²¹⁸ At the time the convictions occurred, there were no long-term residential treatment centers with child care facilities and women-only services.²¹⁹ Indeed, no residential treatment center operating solely for substance-addicted women existed in South Carolina at the time the Policy was implemented.²²⁰ Thus, the solicitors did not know whether any social services were available to the women they prosecuted. Even if they had been aware of the possibility of treatment, they were unwilling to address the question of access to the resources, such as child-care and transportation services, that are necessary to make rehabilitation a viable option.²²¹ One

215. See JA, *supra* note 5, at 879–80, 1062–63, 1413, noted in Brief of Appellants, *supra* note 3, at 14.

216. See Brief of Appellants, *supra* note 3, at 14.

217. See JA, *supra* note 5, at 914–15, noted in Brief of Appellants, *supra* note 3, at 15.

218. See Brief of Appellants, *supra* note 3, at 17.

219. The Charleston County Substance Abuse Commission's women-only "New Life" program was not available until November, 1994, by which time the Policy had been discontinued.

220. Until 1992, there was not one drug treatment program in all of South Carolina designed to meet the specific needs of pregnant and parenting substance-addicted women and their children. See SOUTH CAROLINA COMMISSION ON ALCOHOL AND DRUG ABUSE, ANNUAL REPORT 1991–1992 66 (1992) (announcing the April 1992 opening of South Carolina's first residential treatment program for women).

221. See MICH REPORT VOL. II, *supra* note 207, at 2 ("Barriers to treatment for women include the use of male-oriented therapies in most programs, lack of adequate child care, inadequate financial resources and limited transportation."). These barriers prevent women from obtaining appropriate treatment. See *id.*, at Appendix, *Alcohol and Drug Treatment Services Available for Pregnant Women*. For example, failure to provide child care services "effectively precludes the participation of women in drug treatment." Wendy Chavkin, *Help, Don't Jail Addicted Mothers*, N.Y. TIMES, July 18, 1989, at A21. Similarly, research on appropriate treatment programs for pregnant women indicates "that long-term (12 to 18 months) residential care is the most effective." MICH REPORT VOL. II, *supra* note 207, at 9; see also Wendy Chavkin, *Mandatory Treatment for Drug Use During Pregnancy*, 266 JAMA 1556 (1991); Wendy Chavkin et

woman, Crystal Ferguson, was unable to comply with a MUSC nurse's directive that she enter the hospital's two-week in-patient drug treatment program, since she had no one to care for her young children.²²² Despite the fact that she repeatedly explained her child-care dilemma and requested outpatient treatment, she was arrested for her inability to seek inpatient care.²²³

IV. UTILIZING CRIMINAL PENALTIES TO ADDRESS HEALTH ISSUES MATERIALLY HARMS WOMEN AND THEIR CHILDREN

By January 1990, less than five months after initial implementation, a decision was made to revise the Policy to permit MUSC to threaten arrest if those women identified did not enroll in a drug treatment program.²²⁴ With no research to support the medical efficacy of the Policy, and no input from experts on substance abuse treatment for pregnant women, the Policy was adopted on the basis of anecdotal and discredited evidence.²²⁵ The effects of drugs on fetal development can be determined only through careful analysis of the complicated interplay of dosage, timing and duration of exposure to chemical, genetic and/or other biological factors in addition to other

al., *Reframing the Debate: Toward Effective Treatment for Inner City Drug-Abusing Mothers*, 70 BULL. N.Y. ACAD. MED. 50 (1993). According to the General Accounting Office, the most significant obstacle to pregnant women receiving proper treatment is "the lack of adequate treatment capacity and appropriate services among programs that will treat pregnant women and mothers with young children. The demand for drug treatment uniquely designated for pregnant women exceeds supply." ADMS BLOCK GRANT, *supra* note 193, at 12, 15.

222. While there were four inpatient drug treatment programs in South Carolina, in reality none were available to many substance-dependent pregnant women, because none provided services to children. See Whitner Amicus Brief, *supra* note 200, at 13-14, n.15 (citing ELIZABETH D. JONES & LORI ACKATZ, AVAILABILITY OF SUBSTANCE ABUSE TREATMENT PROGRAMS FOR PREGNANT WOMEN: RESULTS FROM THREE NATIONAL SURVEYS (1992)).

223. See JA, *supra* note 5, at 367-68. Ms. Ferguson was arrested because she refused to go to inpatient treatment because of her child care concerns. However, a White woman, who similarly refused treatment, was able to avoid arrest. See Brief of Appellants, *supra* note 3, at 27.

224. The push for revision was fueled in large part by concern that women were arrested without being given any opportunity for drug treatment. See JA, *supra* note 5, at 1147. Indeed, one of the Policy implementers noted that "[o]f the 12 cases referred under the Policy during that period [October 3 to December 1, 1989], 8 were first identified following admission to Hospital during labor, so there was no opportunity for the mother to enter drug treatment and avoid arrest prior to the delivery." JA, *supra* note 5, at 1427, *quoted in* Brief of Appellants, *supra* note 3, at 21.

225. MUSC relied upon a health care technician's "claim that cocaine use was increasing which was based on 'tick marks' she kept on files in her office." Brief of Appellants, *supra* note 3, at 28 n.28.

considerations.²²⁶ Nonetheless, the Policy did not include a scientifically sound evaluation mechanism designed either to support or assess the efficacy of the Policy.²²⁷ The primary designers of the Policy “were not able to establish the extent of illegal drug use among the MUSC obstetrical population because not all patients were screened, nor could they account for the impact of other regional obstetrical care programs on the clinic’s population.”²²⁸

The Policy discouraged women from seeking medical assistance from health and social service professionals, “the very people who are best able to prevent future abuse.”²²⁹ In fact, MUSC’s own studies and reports indicate that the Policy ultimately deterred women from obtaining necessary prenatal care.²³⁰ Shame, fear of incarceration, and fear of losing one’s children are primary factors that keep substance-dependent mothers from seeking drug treatment, prenatal care and other medical and social services.²³¹ This situation places women and children in greater jeopardy than would have been the case had they received such care,²³² while at the same time increases the cost of providing needed care after-the-fact.²³³

Since MUSC could not determine whether the declining numbers of positive drug tests were the result of women avoiding

226. See Barry Zuckerman, *Drug-Exposed Infants: Understanding the Medical Risk*, 1 FUTURE CHILDREN 26, 26–28 (1991).

227. See Jos et al., *supra* note 17, at 125.

228. *Id.*

229. Cole, *supra* note 8, at 2669; see also Blank, *supra* note 8, at 84.

230. See Brief of Appellants, *supra* note 3, at 22.

231. See Whitner Amicus Brief, *supra* note 200, at 9; Cole, *supra* note 8, at 2667 (“Pregnant women will be likely to avoid seeking prenatal or other medical care for fear that their physicians’ knowledge of substance abuse or other potentially harmful behavior could result in a jail sentence rather than proper medical treatment.”); AMERICAN MEDICAL ASSOCIATION, RESOLUTION 131, TREATMENT VERSUS CRIMINALIZATION—PHYSICIAN ROLE IN DRUG ADDICTION DURING PREGNANCY A-90 (1990) (stating that “[i]t is the policy of the AMA to oppose legislation which criminalizes maternal drug addiction”).

232. According to a study conducted by the Center for Health Policy Research of George Washington University, “fear of criminal prosecution may . . . keep pregnant substance abusers away from vital prenatal care exacerbating possible fetal harm.” GEORGE WASHINGTON UNIV. CTR. FOR HEALTH POLICY RESEARCH, AN ANALYSIS OF RESOURCES TO AID DRUG-EXPOSED INFANTS AND THEIR FAMILIES 78 (1993).

233. The average cost of medical care for the first thirty days after delivery for a cocaine-addicted woman who received prenatal care is \$7000, versus \$31,000 spent caring for the cocaine-addicted woman who did not receive prenatal care. See Michelle D. Wilkins, *Solving the Problem of Prenatal Substance Abuse: An Analysis of Punitive and Rehabilitative Approaches*, 39 EMORY L.J. 1401, 1441 (1990) (citing Telephone Interview with Pat O’Keefe, Director of Communications for Perinatal Addiction Research and Education (Jan. 18, 1990)). Moreover, according to former Assistant Health Secretary Philip Lee, “[e]very dollar invested in drug treatment can save \$7 in societal and medical costs.” *Treat But Don’t Jail Addicts, Study Says*, POST & COURIER (Charleston, S.C.), March 18, 1998, at 1A.

treatment at MUSC or the result of any of a number of other factors, the policy yielded no evidence whatsoever about the effectiveness of punitive intervention with regard to either the health of mothers or the health of children removed from their influence.²³⁴

The Policy did little more than punish women for their substance addiction during pregnancy, rather than address the health problems related to such circumstances. This is so notwithstanding the fact that chronic drug addiction is a disease.²³⁵ The Policy ran afoul of the well-established principle that the imposition of criminal penalties for one's status violates the Eighth Amendment to the Constitution.²³⁶

The United States Supreme Court has long recognized that substance addiction is a disease, and that substance addicts are "proper subjects for [medical] treatment."²³⁷ This precept provided the foundation for the Court's determination in *Robinson v. California* that addiction should be treated as a health problem, and not punished as a crime.²³⁸ The medical community has also long emphasized that "addiction is a chronic illness that is never cured but from which one may nonetheless recover."²³⁹

Despite the wealth of information on the issue, the implementers of the Policy completely ignored the larger structural reasons for why women begin using cocaine in the first place. Answers to questions like these are crucial to finding an effective solution to the problem of addiction. Substance-addiction is caused by complex physical, social and psychological factors. The women most likely to be prosecuted for prenatal cocaine exposure must

234. See Jos et al., *supra* note 17, at 125.

235. According to Dr. June Osborn of the new Physician Leadership on National Drug Policy (an organization of prominent physicians and leaders in the public health field from the Clinton, Bush, and Reagan administrations, which commissioned research from a number of universities), "We've been telling people to 'just say no' when addiction is a biological event." *Treat But Don't Jail Addicts, Study Says*, POST & COURIER (Charleston, S.C.), March 18, 1998, at 1A. See *United States v. Southern Management Corp.*, 955 F.2d 914, 921 (4th Cir. 1992) (both the World Health Organization and the American Psychiatric Association classify substance addiction as a disease).

236. See *Robinson v. California*, 370 U.S. 660, 667 (1962) (holding that addiction cannot be the basis for criminal prosecution under the Eighth Amendment's prohibition against cruel and unusual punishment); see also *Pottinger v. Miami*, 810 F. Supp. 1551, 1556 (S.D. Fla. 1992) (holding that arresting homeless persons for performing such activities as sleeping and standing in public violates the Eighth Amendment).

237. *Linder v. United States*, 268 U.S. 5, 18 (1925) (finding that a physician who provided narcotics to patient in the course of medical treatment for substance addiction did not violate the Narcotics Law).

238. 370 U.S. at 667.

239. See *Southern Management Corp.*, 955 F.2d at 920.

frequently contend with severe life stress which often leads to dependency.²⁴⁰ Studies have concluded that single mothers experience higher levels of stress than most groups, few existing support networks, lower general well-being, and higher rates of depression, all of which put them at risk for physical and emotional illness, including substance abuse.²⁴¹

Often those who become addicted to cocaine are from communities that are extremely poor, alienated from health care and other social services, and plagued by domestic violence, poor educational institutions and few job opportunities.²⁴² Substance-addicted women commonly have histories of childhood sexual abuse and ongoing physical and sexual abuse.²⁴³ For example, in one study 74% of substance-dependent women reported incidents of sexual abuse.²⁴⁴ In another study, 15% of pregnant addicted women reported that they were raped as children, 19% were beaten as children, 21% were raped as adults, and 74% were beaten as adults.²⁴⁵ Studies have shown that between 80% to 90% of substance-addicted women have been victims of rape or incest.²⁴⁶ In addition, these women are often pressured into their first drug experience by the same men who physically abuse them.²⁴⁷ Many experts assert that in order to alleviate the pain and anxiety caused by these life experiences and ongoing maltreatment, many abused women "self medicate" through the use of alcohol, drugs, and prescription medication.²⁴⁸

Given the array of serious and debilitating social and psychological factors that lead to substance addiction, the characterization of women who fall prey to this problem as child abusers is deplorable. Even more troubling, the portrayal of these women as

240. See MICH REPORT VOL. II, *supra* note 207, at 14 ("The majority of addicted women were sexually abused as children, are currently being battered, are children of parents who abused alcohol and other drugs, or are depressed and suffer from low self-esteem.").

241. See Whitner Amicus Brief, *supra* note 200, at 5.

242. See Cole, *supra* note 8, at 2667 ("[S]ubstance abuse is caused by complex hereditary, environmental, and social factors.").

243. See Whitner Amicus Brief, *supra* note 200, at 4.

244. See *id.* (citing N. FINKELSTEIN ET AL., GETTING SOBER, GETTING WELL: A TREATMENT GUIDE FOR CAREGIVERS WHO WORK WITH WOMEN 244 (1990)).

245. See *id.* (citing Dianne O. Regan et al., *Infants of Drug Addicts: At Risk for Child Abuse, Neglect, and Placement in Foster Care*, 9 NEUROTOXICOLOGY AND TERATOLOGY 315, 317 (1987)).

246. Lisa Leff, *Treating Drug Addiction with the Woman in Mind*, WASH. POST, Mar. 5, 1990, at E1, E4.

247. See Whitner Amicus Brief, *supra* note 200, at 4 & n.7 ("The Women's Drug Research Project found that over 85% of the women who used drugs were living with male spouses or partners who were drug abusers.").

248. See *id.* at 5 (citing Hortensia Amaro et al., *Violence During Pregnancy and Substance Use*, 80 AM. J. PUB. HEALTH 575, 578 (1990)).

criminals wrongly assumes that they intend to harm their future children.²⁴⁹ Clearly, this is not the case. As the National Association for Perinatal Addiction Research and Education ("NAPARE") has stated: "These women are addicts who become pregnant, not pregnant women who decide to use drugs and become addicts. They do not want or intend to harm their . . . children by using drugs"²⁵⁰ Indeed, The American Medical Association has maintained that "it is clear that addiction is not simply the product of a failure of individual will power."²⁵¹

Startlingly few resources have been made available for women's substance abuse treatment.²⁵² As a result, there is a severe

249. Many public health groups are opposed to relying on drug tests since they are often inaccurate, do not measure the severity of drug dependency and are not reliable predictors of parental fitness. According to the California Medical Association and a division of the American College of Obstetricians and Gynecologists:

[P]renatal substance abuse by an addicted mother does not reflect willful maltreatment of a fetus, nor is it necessarily evidence that the mother will abuse her child after birth. A woman with a substance abuse problem may genuinely desire to terminate the use of such substances prenatally but may be unable, without access to substance abuse treatment programs, to act on her desire. However, after the child is born, the mother may be able to provide the child with an adequate home environment. In the absence of tangible evidence that she will be unable to do so, she should be permitted to raise her child, with the assistance of family, friends and voluntary social services.

Amicus Curiae Brief of California Medical Association and American College of Obstetricians and Gynecologists, District 9, at 3-4.

250. NATIONAL ASSOCIATION FOR PERINATAL ADDICTION RESEARCH AND EDUCATION, NAPARE POLICY STATEMENT NO. 1, CRIMINALIZATION OF PRENATAL USE: PUNITIVE MEASURES WILL BE COUNTER PRODUCTIVE (1990); *see also* Cole, *supra* note 8, at 2667-68:

Punishing a person for substance abuse is generally ineffective because it ignores the impaired capacity of substance-abusing individuals to make decisions for themselves. In all but a few cases, taking a harmful substance such as cocaine is not meant to harm the fetus but to satisfy an acute psychological and physical need for that particular substance. If a pregnant woman suffers from a substance dependency, it is the physical impossibility of avoiding an impact on fetal health that causes severe damage to the fetus, not an intentional or malicious wish to cause harm.

251. Cole, *supra* note 8, at 2667 (citing *Drug Abuse in the United States: A Policy Report*, in PROCEEDINGS OF THE HOUSE OF DELEGATES, 137TH ANNUAL MEETING OF THE BOARD OF TRUSTEES OF THE AMERICAN MEDICAL ASSOCIATION (June 26-30, 1988)).

252. *See* Whitner Amicus Brief, *supra* note 200, at 11 ("Approximately 80% of the treatment resources in this country are spent treating men.") (citing NATIONAL ASSOCIATION OF STATE ALCOHOL AND DRUG ABUSE DIRECTORS, SURVEY OF STATE ALCOHOL AND DRUG AGENCY USE OF FY 1989 FEDERAL AND STATE FUNDS tbl. 2 (1990) [hereinafter NASADAD SURVEY]).

dearth of treatment programs catering to the specific needs of women in this country.²⁵³ Because substance addiction has historically been a problem largely associated with men,²⁵⁴ pregnant women remain marginalized by the drug and alcohol treatment systems and are often refused treatment for their addictions.²⁵⁵ According to a comprehensive three-year study of perinatal substance abuse in southern states, pregnant women represent less than 1% of the total patients served in substance abuse treatment programs.²⁵⁶ In South Carolina, although an estimated 6385 pregnant women are in need of treatment, only 633 or 9% actually receive it.²⁵⁷ While the federal government, in order to meet the unique treatment needs of women, has provided states with special Women's Set-Aside funds, many states are not using the funds appropriately.²⁵⁸ As a result, many drug-exposed infants and their mothers still go largely untreated.²⁵⁹ In fact, of all funds appropriated for treatment services in South Carolina, the state spends just 16% on treatment for women.²⁶⁰

Meaningful access to prenatal care is particularly important for substance-dependent pregnant women. However, low-income pregnant and post-partum women must contend with barriers to basic medical care due largely to the fact that they often lack adequate

253. See *id.* at 13–14 (citing Beth Glover Reed, *Developing Women-Sensitive Drug Dependence Treatment Services: Why So Difficult?*, 19 J. PSYCHOACTIVE DRUGS 151, 153 (1987)).

254. See *id.* at 11 (the Katzenbach Commission Report issued in 1967 described the substance addict as “likely to be male between the ages of 21 and 31, poorly educated and unskilled, and a member of a disadvantaged ethnic minority group.”).

255. See *id.* at 12 (citing Wendy Chavkin, *Drug Addiction and Pregnancy: Policy Crossroads*, 80 AM. J. PUB. HEALTH 483, 485 (1990)); see also *Elaine W. v. Joint Diseases N. Gen. Hosp.*, 613 N.E.2d 523, 524 (N.Y. 1993) (rejecting hospital policy precluding all pregnant women from drug detoxification services in absence of a determination of medical necessity for such policy under New York Human Rights Law); Lisa Brennan, *Pregnant Addicts Seek Treatment Plan*, LEGAL INTELLIGENCER, Jan. 11, 1994, at 1 (detailing public hearing by Philadelphia Human Relations Commission addressing pregnancy discrimination by Philadelphia drug and alcohol treatment providers).

256. See Whitner Amicus Brief, *supra* note 200, at 12. A review by the Select Committee on Children and Youth of the United States House of Representatives of large urban hospitals revealed that two-thirds did not have anywhere to refer substance-dependent pregnant women for treatment. See *id.* at 13 (citing Donna R. Weston, et al., *Drug Exposed Babies: Research and Clinical Issues*, in ZERO TO THREE 4 (Jeree Pawl, ed., 1989)).

257. See *id.* at 13. (citing NASADAD SURVEY, *supra* note 252, at tbl.3).

258. See *id.* (citing Frederic Suffet et al., *Treatment of the Pregnant Addict: A Historical Overview*, in PREGNANT ADDICTS AND THEIR CHILDREN: A COMPREHENSIVE CARE APPROACH 13, 18–19 (Richard Brotman et al. eds., 1985)).

259. See *id.*

260. See *id.* (citing NASADAD SURVEY, *supra* note 252, at tbl.2).

health insurance or the funds necessary to obtain care.²⁶¹ An estimated 43.5% of all pregnant women in South Carolina do not receive adequate prenatal care.²⁶² This is so despite the fact that it is widely agreed that universal access to prenatal care for pregnant women is the most important means of improving the health of infants.²⁶³ For example, cocaine-addicted women who have at least four prenatal check-ups are half as likely as those who receive no such care to give birth to infants with dangerously low-birth weight.²⁶⁴

Health care access problems are compounded for indigent, drug-addicted pregnant women who also face barriers to adequate drug treatment.²⁶⁵ Indeed, 89% of the directors of drug and alcohol departments in South Carolina report that lack of child care services is the most significant barrier to providing treatment services to pregnant women.²⁶⁶ Access to drug-treatment is an important and necessary component of any meaningful health care regimen for substance-dependent pregnant women and their infants. According to NAPARE:

Important methods for preventing or minimizing fetal harm due to substance abuse by pregnant women include identification of women who are at high risk for being substance abusers, early medical and psychotherapeutic intervention in the pregnancies of substance-abusing women, and access to programs that address the full range of social and health care needs associated with substance abuse.²⁶⁷

Conversely, criminal prosecution exacerbates existing health problems; poor nutrition and inadequate healthcare compound the

261. See ADMS BLOCK GRANT, *supra* note 200, at 36; see also U.S. Panel Urges Universal Access to Prenatal Care, BOSTON GLOBE, Aug. 16, 1989, at 11 (arguing that employers should offer health insurance that includes maternal care).

262. See MICH REPORT VOL. II, *supra* note 207, at 7.

263. See Blank, *supra* note 8, at 84 (citing the Institute of Medicine, the United States Public Health Service Expert Panel on the Content of Prenatal Care, and the United States Congress Office of Technology Assessment). According to the Southern Regional Project on Infant Mortality, "one of the most effective weapons against infant mortality is early, high quality, comprehensive prenatal care." SRPIM REPORT, *supra* note 118, at 6.

264. Andrew Racine et al., *The Association Between Prenatal Care and Birth Weight Among Women Exposed to Cocaine in New York City*, 270 JAMA 1581, 1585 (1993).

265. See Whitner Amicus Brief, *supra* note 200, at 13-14.

266. See Whitner Amicus Brief, *supra* note 200, at 14 (citing ELIZABETH D. JONES & LORI ACKATZ, AVAILABILITY OF SUBSTANCE ABUSE TREATMENT PROGRAMS FOR PREGNANT WOMEN: RESULTS FROM THREE NATIONAL SURVEYS 7 (1992)).

267. Cole, *supra* note 8, at 2668-69.

effects of cocaine in ways that make it virtually impossible to isolate the harm caused by cocaine from other negative influences on childbearing associated with poverty.²⁶⁸

Despite overwhelming evidence that even basic prenatal care improves pregnancy outcomes for all mothers, universal access to prenatal care is still a long way off.²⁶⁹ It would have been more consistent with South Carolina's avowed concern for maternal and fetal health to give expectant mothers access to proper nutrition, counseling, mental health and substance abuse treatment, and adequate prenatal care. Such support is necessary to enable pregnant women to make informed health decisions for themselves and their children.²⁷⁰ Indeed, "[u]nless society is willing to expend considerable resources to overcome the problems of poverty, illiteracy, housing and lack of access to quality prenatal care and meaningful employment for women of childbearing age, the future will continue to look bleak for many children."²⁷¹

While MUSC attempted to justify the Policy as a mechanism for protecting the health of the pregnant woman and her fetus or newborn child, no significant evidence has been proffered to demonstrate that the Policy has had any such salutary effect. Rather, it was punitive in terms of both its orientation and its effect. The implementers of the Policy claimed that they worked diligently to get the women to change their behavior, however, in reality nothing was done for them.²⁷²

268. See Jos et al., *supra* note 17, at 126.

269. See SRPIM REPORT, *supra* note 118, at 6.

270. See Dawn Johnsen, *Shared Interests: Promoting Healthy Births Without Sacrificing Women's Liberty*, 43 HASTINGS L.J. 569, 571 (1992) (arguing for facilitative policies that provide women choices, not coercive and punitive policies that create conflict between women's liberty and the promotion of healthy births).

271. Blank, *supra* note 8, at 83. According to State Council on Maternal, Infant and Child Health:

[L]aw enforcement agencies should not consider prosecution of women for failure to obtain care that isn't available to them. The criminal justice system cannot serve as a mechanism to force women to obtain treatment if the treatment services do not exist. The criminal justice system cannot solve problems of education, treatment, rehabilitation and family support. . . . Criminal sanctions are not a substitute for adequate treatment and, if used at all, should be used only after other less coercive measures have proved inadequate.

MICH REPORT VOL. II, *supra* note 207, at 10–11.

272. The National Institute of Health Office for Protection from Research Risks determined that the Policy constituted experimentation on human subjects conducted without prior examination by and approval from the Internal Review Board. See Jos et al., *supra* note 17, at 120.

Throughout the 1980s and 1990s, in order to capitalize on the public's alarmed response, policy makers nationwide began introducing bills and implementing policies criminalizing maternal drug-dependency,²⁷³ mandating the reporting of substance-dependent individuals to the authorities,²⁷⁴ and separating infants from their mothers.²⁷⁵ While other states abandoned similar efforts in the wake of federal constitutional challenges,²⁷⁶ South Carolina did not, even though virtually every medical, public health and children's rights organization in the country has unequivocally opposed policies that use threats of prosecution to address substance addiction.²⁷⁷ South

273. See Loren Siegel, *The Pregnancy Police Fight the War on Drugs*, in CRACK IN AMERICA, *supra* note 177, at 249 ("During the late 1980s, as the specter of 'crack babies' haunted American political rhetoric, more than two hundred criminal prosecutions were initiated against women in almost twenty states."); see also CAROL S. LARSON, CENTER FOR THE FUTURE OF CHILDREN, OVERVIEW OF STATE LEGISLATIVE AND JUDICIAL RESPONSES 72-84 (Spring 1991) (reporting state legislative and judicial actions taken in response to infants exposed to drugs prenatally); Kary Moss, *Substance Abuse During Pregnancy*, 13 HARV. WOMEN'S L.J. 278, 292-93 (1990) (surveying state laws addressing maternal substance-addiction).

274. Twelve states now have laws requiring the reporting of pregnant women's drug use to child welfare agencies. These states include: Arizona, California, Illinois, Iowa, Massachusetts, Michigan, Minnesota, Oklahoma, South Carolina, Utah, Virginia, and Wisconsin. See, e.g., ARIZ. REV. STAT. ANN. § 13-3620(B) (West 1998); CAL. PENAL CODE § 11165.13 (West 1998); 325 ILL. COMP. STAT. 5/7.3b (West 1998); IOWA CODE ANN. §§ 232.68(2)(f), 232.77(2) (West 1998); MASS. GEN. LAWS ANN. Ch. 119, § 51A (West 1998); MICH. COMP. LAWS § 722.623a (1998); VA. CODE ANN. §§ 54.1-2403.1, 63.1-248.3(A1) (Michie 1998); WIS. STAT. ANN. § 146.0255 (West 1998).

275. A study conducted in Pinellas County, Florida concluded that Black women were ten times more likely than White women to be reported to civil authorities for prenatally exposing an infant to a controlled substance and to have their children taken away from them. See Chasnoff, *supra* note 19, at 1204.

276. From 1977 to the present, prosecutors in more than thirty states have attempted to use existing criminal laws to punish women for behavior during pregnancy that could be harmful to their fetuses. However, with the exception of the South Carolina Supreme Court, every state court of last resort, as well as all intermediate appellate courts and numerous trial courts have rejected the use of child endangerment and other criminal statutes to punish women for their conduct during pregnancy. See, e.g., *Reinesto v. Superior Court*, 894 P.2d 733 (Ariz. Ct. App. 1995); *Reyes v. Superior Court of San Bernadino County*, 141 Cal. Rptr. 912 (4th Dist. 1977); *State v. Ashley*, 701 So.2d 338 (Fla. 1997); *Johnson v. State*, 602 So. 2d 1288 (Fla. 1992); *State v. Gethers*, 585 So.2d 1140 (Fla. Dist. Ct. App. 1991); *Commonwealth v. Welch*, 864 S.W.2d 280 (Ky. 1993); *People v. Hardy*, 469 N.W.2d 50 (Mich. Ct. App. 1991), *amended by* 471 N.W.2d 619 (Mich. 1991); *State v. Gray*, 584 N.E.2d 710 (Ohio 1992); *Collins v. State*, 890 S.W.2d 893 (Tex. Ct. App. 1994); *State v. Dunn*, 916 P.2d 952 (Wash. Ct. App. 1996); *Wisconsin ex re. Angela M.W. v. Kruzicki*, 561 N.W.2d 729 (Wis. 1997). Even the White House Office of National Drug Control Policy under then-President Bush acknowledged that the policies calling for the prosecution of pregnant drug-addicted women had been unsuccessful. THE WHITE HOUSE, NATIONAL DRUG CONTROL STRATEGY REPORT 53 (1990).

277. The American Academy of Pediatrics, American Medical Association, American Public Health Association, American Society on Addiction Medicine, American College of Obstetrics and Gynecology, and the American Nurses Associa-

Carolina's Policy alone unlawfully targeted and needlessly stigmatized Black women, frightening them away from needed prenatal care and placing them in an adversarial relationship with their own fetuses.

Instead of recognizing the symbiotic connection that exists between a woman and her fetus, the Solicitors opted to create an adversarial relationship between the two, pitting one against the other.²⁷⁸ This was so despite the fact that the interests of pregnant women and fetuses are the same; they are one entity, not two separate beings.²⁷⁹ The Policy was enforced for five years, notwithstanding the

tion, among others, have decried the imposition of criminal sanctions as inimical to a physician's role of promoting maternal and fetal health. See Jos et al. *supra* note 17, at 123. Moreover, even the state's own organizations, the South Carolina Alliance for Children and the South Carolina Medical Association, have unequivocally opposed the implementation of such policies as the Policy. See *id.*

278. As Helene Cole noted:

Criminal penalties would also emphasize conflict between the pregnant woman and her fetus, which does not encourage a healthy relationship between the pregnant woman and her future child. On the other hand, providing education and treatment emphasizes cooperation and trust between the pregnant woman and her physician and facilitates a more emotionally positive relationship after birth.

Cole, *supra* note 8, at 2669 (citing Coordinating Federal Drug Policy for Women, Infants and Children: Hearing before Senate Comm. On Governmental Affairs, 101st Cong. 1 (1989)).

279. The Supreme Court of Illinois, in *Stallman v. Youngquist*, recognized, in refusing to allow a cause of action for maternal prenatal negligence, the unique relationship between the pregnant-women and the fetus:

Since anything which a pregnant woman does or does not do may have an impact, either positive or negative, on her developing fetus, any act or omission on her part could render her liable to her subsequently born child Any action which negatively impacted on fetal development would be a breach of the pregnant woman's duty to her developing fetus. Mother and child would be legal adversaries from the moment of conception until birth. . . . Holding a mother liable for the unintentional infliction of prenatal injuries subjects to State scrutiny all the decisions a woman must make in attempting to carry a pregnancy to term, and infringes on her right to privacy and bodily autonomy. . . . Logic does not demand that a pregnant woman be treated in a court of law as a stranger to her developing fetus It would be a legal fiction to treat the fetus as a separate legal person with rights hostile to and assertable against its mother. The relationship between a pregnant woman and her fetus is unlike the relationship between any other plaintiff and defendant. No other plaintiff depends exclusively on any other defendant for everything necessary for life itself. No other defendant must go through biological changes of the most profound type, possibly at the risk of her own life, in order to bring forth an adversary into the world. It is, after all, the whole life of the pregnant woman which impacts on the development of the fetus. As opposed to the third-party defendant, it is the

fact that it placed the interests of the fetus above those of the mother and unconstitutionally penalized women for their decision to carry their pregnancies to term.²⁸⁰

The United States Supreme Court has consistently rejected claims that fetal rights should trump maternal rights, declining invitations to find a compelling state interest in protecting viable fetuses that would require sanctions or compulsory treatment of the mother.²⁸¹ In *Roe v. Wade*, the Supreme Court maintained that "the word 'person,' as used in the Fourteenth Amendment, does not include the unborn."²⁸² This holding was reaffirmed by *Planned Parenthood v. Casey*, in which Justice Stevens opined that "as a matter of federal constitutional law, a developing organism that is not yet a 'person' does not have what is sometimes described as a 'right to life.' This has been and, by the Court's holding today, remains a fundamental premise of our constitutional law governing reproductive autonomy."²⁸³ While acknowledging that a state may have an "important and legitimate interest in potential life," the Court has steadfastly rejected claims that fetuses are entitled to the same constitutional status as women.²⁸⁴

mother's every waking and sleeping moment which, for better or worse, shapes the prenatal environment which forms the world for the developing fetus. That this is so is not a pregnant woman's fault: it is a fact of life.

531 N.E.2d 355, 359-60 (Ill. 1988).

280. See Roberts, *supra* note 80, at 1958 ("The same proliferation of prosecutions against affluent, white women who abuse alcohol or prescription medication would be unthinkable. Society is much more willing to condone the punishment of poor women of color who fail to meet the middle-class ideal of motherhood. Thus, the very conception of using drugs during pregnancy as a crime is rooted in race.").

281. See *Planned Parenthood v. Casey*, 505 U.S. 833, 913-14 (1992) (holding that developing fetuses are not recognized as persons under the law); *Thornburgh v. American College of Obstetricians and Gynecologists*, 476 U.S. 747, 779 n.8 (1986) (striking down statutes that compromised maternal health in favor of fetal survival); *Colautti v. Franklin*, 439 U.S. 379, 397 (1979) (invalidating a statute that failed to guarantee that a woman's health always prevail over the life and health of her fetus).

282. 410 U.S. 113, 158 (1972).

283. 505 U.S. at 913-14 (Stevens, J., concurring).

284. See *id.* at 853, 871, 873. While the Court ruled that "the State has legitimate interest from the outset of the pregnancy in protecting . . . the life of the fetus that may become a child," *id.* at 846, Justice Stevens explicitly noted:

The suggestion that states are free to declare a fetus a person . . . assumes that a state can curtail some persons' constitutional rights by adding new persons to the constitutional population . . . If a fetus is not part of the constitutional population, under the national constitutional arrangement, then states have no power to overrule the national arrangement by themselves declaring that fetuses have rights competitive with the constitutional rights of pregnant women.

The mother-fetus relationship is unlike any other recognized in law and thus cannot be reconciled within the adversarial legal framework. The imposition of criminal sanctions against a pregnant woman for actions that may detrimentally affect her developing fetus creates a dichotomy between the two where the rights of the entity she carries can be inimical to her own. This absurdity can lead to unintended and dangerous consequences. Virtually anything a pregnant woman does affects her fetus either positively or negatively. As a result, any act or omission on her part would have the potential of rendering her criminally liable for child abuse.²⁸⁵

The question of a pregnant woman's medical care is illustrative of this dilemma. Any treatment she elects to receive to safeguard her own health could place her fetus in jeopardy. For example, many modern medical treatments and therapies have far-reaching consequences that are antithetical to fetal well-being. According to a coalition of health care providers and substance abuse treatment organizations, "chemotherapy or radiation treatment for cancer, or even the administration of drugs commonly used during labor and delivery . . . can themselves cause fetal central nervous system depression, anoxia, hypothermia, low Apgar Scores, impaired metabolic responses, and neurological depression."²⁸⁶

Hence, any action or omission by the pregnant women could constitute a breach of her duty to promote and protect the health of her fetus. Creating an antagonistic relationship between a woman and her fetus, while facilitating litigation in our oppositional system, denies the reality of pregnancy. According to one court:

It would be a legal fiction to treat the fetus as a separate legal person with rights hostile to and assertable against its mother No other defendant must go through biological changes of the most profound type, possibly at the risk of her own life, in order to bring forth an adversary into the world. It is, after all, the whole life of the pregnant woman which impacts on the development of the fetus. As opposed to the third-party defendant, it is the mother's every waking and sleeping moment which, for better or worse, shapes the prenatal environment which forms the world for

Id. at 913 n.2 (Stevens, J., concurring in part and dissenting in part) (quoting Ronald Dworkin, *Unremunerated Rights: Whether and How Roe Should be Overruled*, 59 U. CHI. L. REV. 38, 400-01 (1992)).

285. See *Stallman v. Youngquist*, 531 N.E.2d 355, 359 (1988) (refusing to recognize tort of maternal prenatal negligence).

286. See *Lindesmith Center Amicus Brief*, *supra* note 158, at 147 n.20.

the developing fetus. That this is so is not a pregnant woman's fault: it is a fact of life.²⁸⁷

Not only did the implementors of the Policy allow fetal rights to overwhelm maternal rights, they empowered government to scrutinize any decision made by a pregnant woman and thus violated her constitutionally protected right to privacy and liberty. The right to privacy in reproductive decision-making, guaranteed under the Fourteenth Amendment to the Constitution, encompasses a woman's right to become pregnant and to carry a pregnancy to term as well as her right to terminate an unwanted pregnancy.²⁸⁸ By penalizing women who gave birth and preventing chemically-dependent women from making independent choices, free from government coercion, about whether or not to carry their pregnancies to term, the Policy violated the right to privacy guaranteed by the United States Constitution.

The United States Supreme Court has unequivocally held that the right to procreate is a fundamental civil liberty.²⁸⁹ The Constitution not only protects women from being forced to terminate wanted pregnancies, it also protects them from measures penalizing them for carrying their pregnancies to term.²⁹⁰ Despite the well-documented fact that maternal and infant health are better served by

287. *Stallman*, 531 N.E.2d at 360; see also *State v. Ashley*, 701 So. 2d 338 (Fla. 1997) (not allowing an expectant mother to be criminally charged with the death of her child resulting from self-inflicted injuries during the third trimester of pregnancy).

288. See *Casey*, 505 U.S. at 859.

289. See *Cary v. Population Servs. Int'l.*, 431 U.S. 678 (1977); *Paul v. Davis*, 424 U.S. 693, 713 (1976); *United States v. 12 200-ft. Reels of Super 8mm Film*, 413 U.S. 123, 127 n.4 (1973); *Eisenstadt v. Baird*, 405 U.S. 438, 453 (1972); *Skinner v. Oklahoma*, 316 U.S. 535, 541 (1942); see also *State v. Brown*, 326 S.E.2d 410 (S.C. 1985) (holding that the prohibition against cruel and unusual punishment is violated where a suspended sentence is conditioned on the defendant's castration).

290. See *Arnold v. Board of Educ. of Escambia County*, 880 F.2d 305, 311 (11th Cir. 1989) ("There simply can be no question that the individual must be free to decide to carry a child to term."). Most recently, in *Casey*, the Supreme Court noted that its decision in *Roe v. Wade*, 410 U.S. 113 (1973), "has been sensibly relied upon to counter" attempts to interfere with a woman's decision to become pregnant or to carry to term. 505 U.S. at 859. Similarly, in *Cleveland Bd. Of Educ. v. LaFleur*, 414 U.S. 632 (1974), the Court declared unconstitutional a rule mandating that pregnant school teachers take unpaid maternity leave at an arbitrary time during their pregnancy. The Court acknowledged that "freedom of personal choice in matters of marriage and family life is one of the liberties protected by the Due Process Clause of the Fourteenth Amendment," and struck down the rule because, "[b]y acting to penalize the pregnant teacher for deciding to bear a child, overly restrictive maternity leave regulations can constitute a heavy burden on the exercise of these protected freedoms." 414 U.S. at 639-40. Certainly, the threat of prosecution and imprisonment constitutes a far greater burden on the exercise of protected reproductive freedoms than an excessively restrictive maternity leave policy. See MICH REPORT VOL. III, *supra* note 30, at 10.

drug treatment, counseling and the provision of prenatal care, the implementers of the Policy chose to prosecute and incarcerate substance-dependent women for becoming pregnant and bearing children. The women prosecuted under the Policy would not have been prosecuted or even charged with a crime had they terminated their pregnancies. Hence, they were prosecuted for exercising their constitutional right to procreate.

The women subjected to the Policy were not only punished for their decision to continue their pregnancies despite their addiction problems, but were more severely penalized than they would have been had they been convicted for other criminal offenses such as drug possession. Because the women were punished more harshly than either substance-dependent men²⁹¹ or nonpregnant women, the severity of the penalty can only be due to the fact that they were pregnant. Moreover, the Policy's intrusion into women's lives to deter behavior during pregnancy also implicated a woman's right to bodily integrity and her fundamental and wide-ranging "right to be let alone."²⁹² Because the fetus is physically part of a woman's body, her every action during pregnancy could potentially become a matter of criminal investigation.²⁹³

291. No male patients at MUSC were ever arrested under the Policy and charged with possession based solely on a positive urine drug screen, see JA, *supra* note 5, at 1280, noted in Brief of Appellant, *supra* note 3, at 16, even though scientific research has indicated that drug or alcohol use can damage sperm and thus substance-addicted men who impregnate women can harm a developing fetus. See Ricardo A. Yazigi et al., *Demonstration of Specific Binding of Cocaine to Human Spermatozoa*, 14 JAMA 1956 (1991); Ruth E. Little and Charles F. Sing, *Father's Drinking and Infant Birth Weight: Report of an Association*, 36 TERATOLOGY 59 (1987).

292. *Olmstead v. United States*, 227 U.S. 438, 478 (1928) (Brandeis, J., dissenting). In this regard, the Supreme Court reiterated in *Casey* that:

It is settled now, as it was when the Court heard arguments in *Roe v. Wade*, that the Constitution places limits on a State's right to interfere with a person's most basic decisions about family and parenthood, as well as bodily integrity.

505 U.S. at 849 (citations omitted).

293. See *Whitner v. State of South Carolina*, 492 S.E.2d 777, 788 (S.C. 1997) (Moore, J., dissenting):

In construing this statute to include conduct not contemplated by the legislature, the majority has rendered the statute vague and set for itself the task of determining what conduct is unlawful. Is a pregnant woman's failure to obtain prenatal care unlawful? Failure to quit smoking or drinking? Although the majority dismisses this issue as not before it, the impact of today's decision is to render a pregnant woman potentially criminally liable for myriad acts which the legislature has not seen fit to criminalize. To ignore this 'down the road' consequence in a case of this import is unrealistic.

The unconstitutional burdens placed on Black women's reproductive autonomy were further exacerbated by the fact that there were no drug treatment facilities available to the pregnant women targeted under the policy²⁹⁴ and that it is virtually impossible to treat one's own addiction.²⁹⁵ Even the sole, and in this case undesired, option of terminating one's pregnancy in order to avoid the terrible dilemma engendered by the Policy, was not a real option for many of those targeted.²⁹⁶ Thus MUSC's actions violated the women's right to reproduce and established a pernicious and discriminatory standard that allowed the State to determine which women were fit to reproduce, thereby denying the humanity of those prosecuted.²⁹⁷

See also *Stallman v. Youngquist*, 531 N.E.2d 355, 361 (Ill. 1988) (holding that no cause of action will lie for maternal prenatal negligence).

294. According to a 1991 report of the General Accounting Office (GAO), the most significant barrier to women's drug treatment "is the lack of adequate treatment capacity and appropriate services among the programs that will treat pregnant women and mothers with young children. The demand for drug treatment uniquely designed for pregnant women exceeds supply." ADMS BLOCK GRANT, *supra* note 200, at 4. A 1990 survey estimated "that less than 14 percent of the 4 million women needing drug treatment received such treatment." *Id.* at 1.

295. Overcoming addiction is a long and arduous process. Holding someone criminally liable in the middle of recovery undermines the entire process and ignores the fact that drug-addiction is a disease, and that it is extremely difficult to overcome on one's own. See PUNISHING WOMEN FOR THEIR BEHAVIOR DURING PREGNANCY, *supra* note 6, at 9; see also *Drugs During Pregnancy: Tragic, But Not Criminal*, N.J. L.J., May 31, 1990, at 9; Editorial, *Pregnancy and Drugs: Should Addicts Be Forced to Abort?*, S.F. CHRON., Oct. 5, 1989, at A22.

296. See Helen L. Smits, *Women, Health, and Development: An American Perspective*, 104 ANNALS OF INTERNAL MED. 263, 263 (1986) (stating that women in the United States have decreasing access to contraceptives). Moreover, there is no federal or state funding for abortion services for poor women, like those targeted under the Policy. An indigent Black woman who chooses to terminate a pregnancy in order to escape prosecution is disproportionately more likely to be denied information on how to secure an abortion and much less likely to receive governmental financial aid for one. See *Rust v. Sullivan*, 500 U.S. 173 (1991); *Webster v. Reproductive Health Services*, 492 U.S. 490 (1989); *Harris v. McRae*, 448 U.S. 297 (1980) (states participating in the Medicaid program are not obligated to fund medically necessary abortions); *Maher v. Roe*, 432 U.S. 464 (1977); see also Dorothy Roberts, *Rust v. Sullivan and the Control of Knowledge*, 61 GEO. WASH. L. REV. 587, 596 (1993) (of the four million women who used Title X clinics, 28% were Black, representing 53% of Black women and just 32% of White women). Consequently, poor, Black women were more likely to be forced to continue their pregnancies, and were then at higher risk than White women of being prosecuted for maternal drug-dependence.

297. See Roberts, *supra* note 19, at 1463-64:

Such imposition of a government standard for childbearing is one way that society denies the humanity of those who are different. . . . In other words, the prosecution of crack-addicted mothers infringes upon both a mother's right to make decisions that determine her in-

South Carolina has presented substance-dependent Black mothers the Hobson's choice of foregoing necessary prenatal care, terminating her pregnancy, or risking prosecution and incarceration.²⁹⁸ Policies such as South Carolina's are not only ineffective in treating substance addiction, but run counter to efforts to promote the health of mothers, fetuses and infants. The Policy was thus little more than an experiment conducted, without their consent, on poor, Black women to determine whether threats of prosecution would alter maternal behavior.

CONCLUSION

Popularly held and firmly entrenched beliefs about the role and proper position of Black women in society have deep historical roots reaching back into slavery. This matrix of historical memory and contemporary images have shaped socio-political attitudes towards Black motherhood for centuries. Enduring negative iconographic representations of Black maternity illustrate and underscore the continuing impact of this country's searing legacy of oppression. The extent to which Black women have been defined by pejorative representations and stereotypes, coupled with the degree to which many Americans have internalized and, consciously or unconsciously, act in reliance upon these debilitating beliefs, informs the discussion of the origin and true significance and effect of the Policy.

To be sure, the Policy was intimately interconnected to larger cultural and social norms.²⁹⁹ The drafters of the Policy integrated

dividual identity and her right to be respected equally as a human being by recognizing the value of her motherhood.

298. Numerous courts dismissing prosecutions against women who gave birth despite an addiction problem have recognized the possibility of coerced abortions. See, e.g., *Johnson v. State*, 602 So.2d 1288, 1296 (Fla. 1992) ("Prosecution of pregnant women for engaging in activities harmful to their fetuses or newborns may also unwittingly increase the incidence of abortion."); *State v. Gethers*, 585 So. 2d 1140, 1143 (Fla. Dist. Ct. App. 1991) ("Potential criminal liability would also encourage addicted women to terminate or conceal their pregnancies."); *People v. Morabito*, 580 N.Y.S.2d 843 (Geneva City Ct. 1992), *aff'd* slip op. (Ontario County Ct. 1992); *People v. Bremer*, 90-32227-FH slip op. at 14 (Mich. Cir. Ct. Jan. 31, 1991), *appeal dismissed*, No. 137619 (Mich. App. July 14, 1992); *Commonwealth v. Pellegrini*, No. 87970 slip op. at 9 (Mass. Super. Ct. Oct. 15, 1990). Indeed, a policy of prosecution may have resulted in at least one coerced abortion. In February 1992, a woman was charged with reckless endangerment because she was allegedly sniffing paint fumes while she was pregnant. Twelve days after her arrest she obtained an abortion. Shortly after the abortion the charges were dropped. See Gail Stewart Hand, *Women or Children First?*, GRAND FORKS HERALD, July 12, 1992, at 1.

299. Americans share a historical experience that has caused individuals within this culture to irrationally and often unknowingly attach significance to race. See

their own moral values and biases into the formulation of the program, without expressly articulating their belief that indigent Black women are immoral and therefore unfit mothers. Not only did the ill-conceived Policy discriminate against Black women, it also seriously threatened the health of these women and their children. Rather than deal with the real issues of poverty, racism and sexism that were conspicuously present, or the fact that the targeted women lacked meaningful access to birth control, prenatal care, and drug-treatment services, the Policy framers determined that being addicted to drugs while carrying a pregnancy to term constituted *per se* child endangerment.

Instead of fulfilling its mission to aid those who sought medical treatment, MUSC chose to penalize substance-dependent pregnant women for their efforts to raise a family and overcome difficult health problems. The decision to criminalize pregnancy and child-bearing for substance-dependent Black women both dehumanizes and degrades those whom society sees as unfit and undeserving of being mothers. In so doing, the Policy continued the unwritten social policy of undermining and discouraging Black motherhood.

Lawrence, *supra* note 173, at 328-344 (describing the psychological dynamics of unconscious racism).